

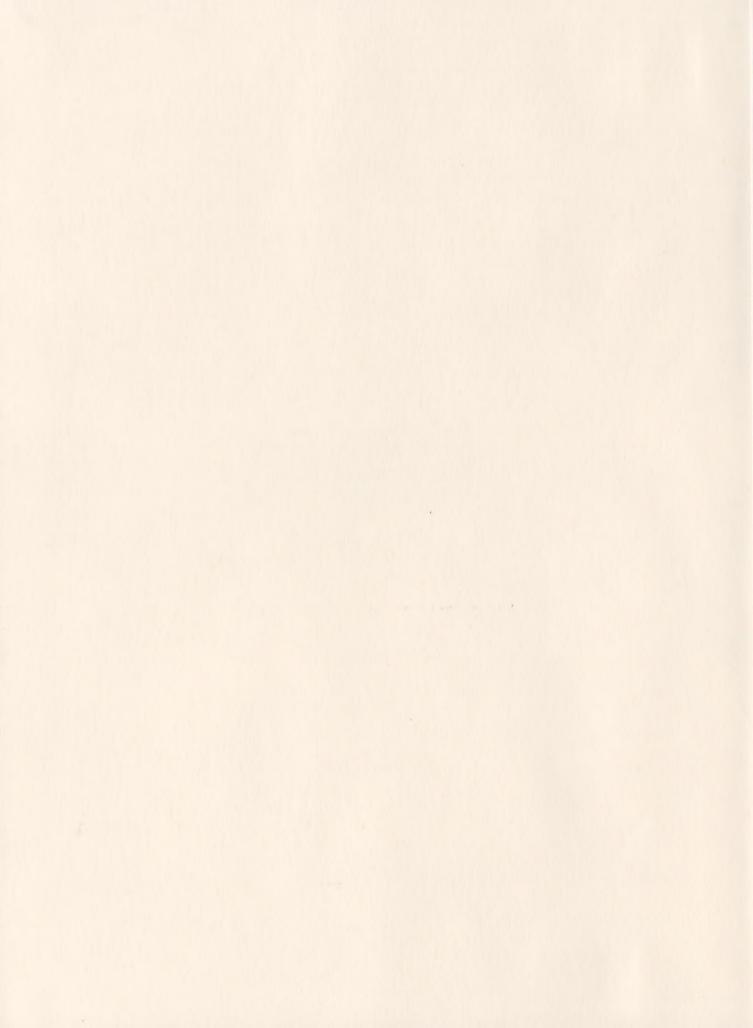


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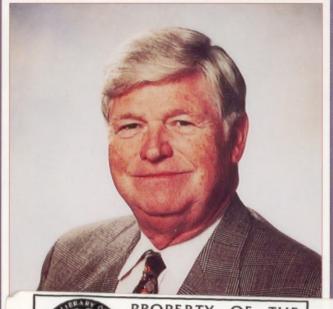
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ELECTIONS . AWARDS

Michigan Medicine







1997 MSMS
House of Delegates
Digest of Proceedings



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MichiganMedicine

COVER STORY



1997-98 MSMS President Peter A. Duhamel, MD

year in office.

MSMS Annual Meeting 1997 House of Delegates shapes policy 8

Once again, physician-assisted suicide was the subject which generated the greatest debate as the 1997 MSMS House of Delegates convened May 2-4. Proposed revisions in MSMS structures and the selection of MSMS leaders also drew much interest and debate at the meeting, held for the first time ever in scenic Traverse City in Michigan's northern lower peninsula. MSMS delegates considered 118 resolutions and 12 Board reports, elected new officers and learned from guest speakers. Details follow in this month's issue of your Michigan Medicine, while photos convey the flavor of the moment.

FEATURES

Opening of the House of Delegates Speaker Dorothy M. Kahkonen, MD, and Vice Speaker Paul O. Farr, MD, presided.

1997 Resolutions

The delegates considered 118 resolutions and 12 Board reports, covering topics ranging from land mines to expansion of the MSMS Board to frequency of HCFA payments for home health care.

Elections 28

Cathy O. Blight, MD, Flint pathologist, was elected MSMS president-elect, the second female physician to win the title. Krishna K. Sawhney, MD, Taylor surgeon and Kenneth H. Musson, MD, Traverse City ophthalmologist, were returned as chair and vice-chair of the MSMS Board of Directors.

Presidential addressesInstalled May 3 as MSMS president, Peter A. Duhamel, MD, Rochester Hills surgeon, called for physicians to increase their community service. W. Peter McCabe, MD, outgoing president, reflected on his

July 1997 Volume 96, Number 7

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FEATURES



Medical students Charlene An, U-M, Medical Student Section chair; Peter Y. Watson, WSU, and Brian West, WSU consider House debate.

Awards 40

Doctor McCabe bestowed MSMS Presidential Citations on three distinguished individuals—Busharat Ahmad, MD; Harvey L. Gass, MD, and Eunice Ott. Other awards went to presidents of national medical specialties, to the physician best exemplifying the ideals of the rural family doctor, and to the Class of '47—MSMS members who graduated from medical school 50 years ago.

Life, Retired Physicians 42

Physicians who achieved permanent, dues-exempt MSMS membership status during the past year.

Board Report 45

Doctor Sawhney summarized MSMS activities of the past year, and introduced reports stemming from 1996 resolutions referred to the Board.

Speakers Report 50

What has happened to the 100-plus resolutions handled by the 1996 MSMS House of Delegates.

Delegates' Attendance Record 65

OTHER TOPICS

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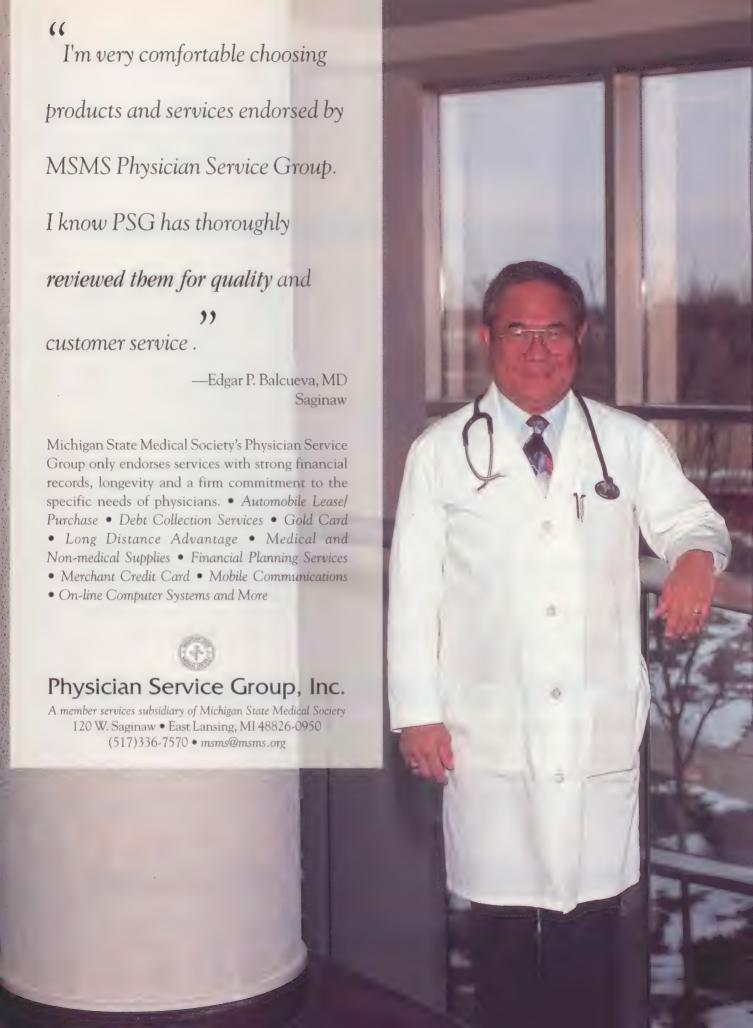
By David K. Fox

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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1997 MSMS House of Delegates



Delegates at MSMS annual meeting tackled suicide, governance issues

The 1997 MSMS House of Delegates May 2-4 shifted the society's stance, adopting AMA policy that physicians should not participate in physician-assisted suicide. In this most-publicized outcome of the MSMS annual meeting, the delegates also said that physicians must aggressively respond to the needs of patients at the end of life.

Other issues which drew many physicians to testify at the microphones revolved around proposed revisions in MSMS structures and governance. Resolutions and board reports on those topics sought ways to broaden and diversify membership on the MSMS Board, House, and AMA delegation.

These and many more events, including elections of new MSMS officers, captured the delegates' attention during the three-day session, held for the first time in Traverse City. Throughout the following pages, you will find complete details on the developments at the 132nd annual meeting. For more background, you may check the MSMS Internet home page and the Michigan Medicine button at http://www.msms.org/.

Opening of the House of delegates

Speaker Dorothy M. Kahkonen, MD and Vice-Speaker Paul O. Farr, MD, presided over the 132nd Annual Session of the House of Delegates of the Michigan State Medical Society which convened at 7:30 p.m. Friday, May 2, 1997 at the Grand Traverse Resort, Traverse City.

Invocation

The Speaker called upon The Reverend Doctor Homer E. Nye to give the invocation.

Report of Committee on Credentials and Tellers

Chairman Charles J. Heyka, MD, reported a quorum seated, the majority of whom were not from any one county.

Report of the Committee on Rules and Order of **Business**

Chairman Thomas J. Zuber, MD, reported the actions of the Committee on Rules and Order of Business as follows:

Order of Business: The Committee on Rules and Order of Business approved the Order of Business for the 1997 Annual Session as printed in the Delegates' Handbook.

Late Resolutions: Eleven late resolutions were presented to the Committee. The following were accepted for introduction:

Resolution 108-97A - "Board Certification" submitted by Harvey W. Halberstadt, MD, Oakland County.

Resolution 109-97A - "Change Health Care Financing Administration Rules to Include Psychiatric Outpatient Programs Within the Family Medicine Exemption" submitted by Harvey W. Halberstadt, MD, Oakland County, for the MI Psychiatric Society.

Resolution 110-97A - "Medication Information" submitted by Robert S. Levine, MD, for the Oakland County Delegation

Resolution 111-97A - "Automobile Safety Recalls" submitted by Robert S. Levine, MD, for the Oakland County Delegation

Resolution 112-97A - "Renewal of Drivers Licenses by Mail" submitted by Jaime V. Aragones, MD, for the Oakland County Delegation

Resolution 113-97A - "Fee Splitting" submitted by Joseph A. Arena, MD, for the Oakland County Delegation

Resolution 114-97A - "Assignment of Student Delegates and Alternate Delegates" submitted by Peter T. Muller, MD, for the Oakland County Delegation

Resolution 115-97A - "Noise Levels in Public Places" submitted by Gertraud Wollschlaeger, MD, for the Oakland County Delegation

Resolution 116-97A - "Insurance Company Payment Denials" submitted by Peter S. Chang, MD, for the Young Physicians Section

Resolution 117-96A - "MSMS House of Delegates Representation" submitted by Rudy W. Stefancik, MD, Houghton County

COMMITTEE ON CONSTITUTION AND BYLAWS

Lourdes V. Andaya MD, Chair

The Committee on Constitution and Bylaws is a House of Delegates Reference Committee, and a standing committee of the MSMS Board. The Committee met on May 3, 1997, during the 1997 House of Delegates, and made the following recommendations:

The Committee recommended adoption of the following changes to Section 20.50:

HOSPITAL ORGANIZED MEDICAL STAFF SECTION -To provide representation for the interests of hospital medical staffs and of other delivery systems within the structure of the Michigan State Medical Society, there shall be a an Hospital Organized Medical Staff Section composed of MSMS members, one to be elected by and from the active voting physician members with clinical privileges of each JCAH JCAHO - accredited hospital in Michigan, and each other delivery system accepted by the Governing Council.

The purpose of this Section is to provide a direct means to address the relationship between MSMS members and hospital organized medical staffs.

In addition, whenever Hospital Medical Staff Section appears in the MSMS Constitution and Bylaws it will be changed to read Organized Medical Staff Section.

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The Committee also recommended adoption of the proposed changes to the Constitution and Bylaws of the MSMS Organized Medical Staff Section as follows:

7.00HOSPITAL ORGANIZED MEDICAL STAFF SEC-TION. There shall be a special section for physicians OF MEDICAL STAFFS OF HOSPITALS AND OTHER DELIVERY SYSTEMS.

7.1PURPOSE. The purpose of this section is to provide a direct means to address the relationship between members of MSMS and the medical staffs of Michigan Hospitals AND OF OTHER DELIVERY SYSTEMS.

7.2MEMBERSHIP. Membership in the section shall be limited to those physicians who are elected as representatives or alternate representatives by the physicians of each JCAHO-Accredited hospital medical staff AND EACH MEDICAL STAFF OF OTHER DELIVERY SYSTEMS ACCEPTED BY THE GOVERNING COUNCIL. The representative and alternate representative must be both MSMS and AMA members.

7.21The representative and alternate representative shall be properly certified by the president or secretary of the medical staff of each hospital OR OTHER DELIVERY SYSTEM.

7.33TERM. Governing Council members, including the Delegate and Alternate Delegate shall serve terms of two years, beginning at the conclusion of the Annual Meeting at which they were elected AND ENDING AT THE CONCLUSION OF THE SEC-OND ANNUAL MEETING AFTER THEIR ELECTION. Any Governing Council member who ceases to be a certified representative of his medical staff during his term shall complete his term on the Governing Council, but shall not be eligible for re-election.

7.41RULES OF ORDER. Only duly selected representatives to the Hospital ORGANIZED Medical Staff Section shall have the right to vote at the business meeting of the section. In the absence of the representative, the alternative representative shall be seated as the voting representative for the medical staff of that hospital OR OTHER DELIVERY SYSTEM. The meeting shall be open to any member of the Michigan State Medical Society. The meeting shall be conducted pursuant to rules of procedure adopted by the Governing Council of the section and approved by the MSMS Board of Directors.

The Committee also recommended that a vote of the Delegates be taken to waive the time requirement for implementation of bylaws' changes as set forth in Section 25.00 of the MSMS Constitution and Bylaws. The House voted to wave the time requirement.

The 1997 House adopted these amendments to the MSMS Bylaws and the OMSS Bylaws effective immediately. The appropriate changes are being made to both the MSMS and OMSS Bylaws.

The Reference Committee on Constitution and Bylaws recommended to the House adoption of the following amendment to the Bylaws on second reading:

12.20 DELEGATES-AT-LARGE-EX OFFICIO MEMBERS

The Chief Medical Officer of the Michigan Department of Community Health, if an active MSMS member, shall be an ex-officio member of the House of Delegates, but without power to vote therein...

The 1997 House of Delegates adopted this amendment on second reading and the appropriate changes are being made to the Bylaws.

The Committee recommended to the 1997 House, on first reading, the addition of the Michigan Chapter of the American College of Cardiology to the list of recognized specialty organizations in Section 20.10 of the Bylaws. organizations.

The House adopted this amendment on first reading. Before the Bylaws are changed, the House will consider and vote on this amendment in 1998.

The Committee recommended to the 1997 House, on first reading, the addition of the following subsection to Section 2.00 "Membership—Classification—Election," and that subsequent renumbering be made in Section 2.00:

2.50 ACTIVE STATUS - PART-TIME DUES. A member who works than twenty hours per week may be placed in the part-time dues category. Dues for this category will be one-half the annual active membership dues rate. Members in this category will have all the privileges of active membership. Eligibility for this category will be verified on a yearly basis.

The House adopted this amendment to the Bylaws on first reading. Before the Bylaws are changed, the 1998 House of Delegates will consider and vote on this amendment.

The Reference Committee on Constitution and Bylaws as a standing committee discussed a recommendation made to the Judicial Commission by Legal Counsel. Legal Counsel has recommended that the Ethics Committee and the Mediation Committee be designated the Peer Review/Ethics Committee and the Peer Review/Mediation Committee. Legal Counsel stressed the importance of having "Peer Review" in the name because it affords legal protection from the subpoena of the committee's records by attorneys of individuals unhappy with the committee's rulings.

The Committee recommended that "Ethics Committee" be changed to "Peer Review/Ethics Committee" in subsections 7.50; 7.60; 7.70; 7.80; 7.90; 8.10; 8.20; 8.30; 8.40; 8.50; 8.60; 8.80; 10.24; and 10.30. The Committee also recommended that "Mediation Committee" be changed to "Peer Review/Mediation Committee" in subsection 10.10. The Committee further recommended that a vote be taken to waive the time requirement for bylaws amendments to become effective.

The House first voted to waive the time requirement, and the time requirement was waived by the 75 percent of delegates present. The House adopted the proposed change to the Bylaws effective immediately, and the changes are being made to the Bylaws.

1997 Resolutions

Delegates tackle issues from tobacco marketing to end-of-life therapy

RESOLUTION 1-97A

Owen M. Berow, MD, and Ronald L. VanderLugt, MD, Kalamazoo County

Title: Health Care Financing Administration (HCFA) Policy on Qualification for Home Health Services When Topical Medication Cannot be Administered by the Patient. ADOPTED AS AMENDED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to use reasonable and appropriate measures to change Health Care Financing Administration (HCFA) policy regarding the definition of skilled care to include topical medications, including eye drops, in extenuating circumstances; and to inform the public of the potential negative consequences of the current policy.

RESOLUTION 2-97A

Owen M. Berow, MD, Kalamazoo County

Title: Medicare Policy Regarding Payment for Diagnostic Medical Tests. Substitute Resolution (in lieu of Resolutions 2-97A and 18-97A) ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to support revision of the Health Care Financing Administration (HCFA) policy regarding payment for diagnostic medical tests that are deemed necessary by a beneficiary's personal physician and are within the boundaries of generally accepted standards of practice set by the medical profession, and mandates for Medicare carriers to advise patients that such denials are HCFA policy and the government practice of medicine; and be it further

RESOLVED: That MSMS, through the MSMS Liaison Committee with Third Party Payers, pursue adoption of policies by the Michigan Medicare carrier that allow payment for diagnostic tests at a frequency deemed necessary by a beneficiary's personal physician and within the boundaries of generally accepted standards of practice set by the medical profession.

RESOLUTION 3-97A

Thomas J. Zuber, MD, Midland County Title: Michigan Medicaid Physician Fee Schedule Update. APPROVED.

RESOLVED: That MSMS seek legislation to upgrade the Michigan Medicaid fee schedule to within 10% of the 1997 Medicare payment schedule, and that this more reasonable payment schedule be incorporated into the next Michigan state budget.

RESOLUTION 4-97A

Thomas I. Zuber, MD, Midland County Title: Governor's Update on Michigan Medicaid Payments to Physicians. APPROVED.

RESOLVED: That MSMS request a conference with Governor Engler to resolve the current problems with the Michigan Medicaid physician fee schedule; and be it further

RESOLVED: That MSMS actively seek inclusion in Governor Engler's future budget proposals more equitable reimbursements to physicians, by upgrading the Michigan Medicaid physician fee schedule to within 10% of the 1997 Medicare payment schedule.

RESOLUTION 5-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Amendments to the MSMS Hospital Medical Staff Section Bylaws. ADOPTED - IMMEDIATELY WITH A 75% VOTE.

RESOLVED: That the MSMS Organized Medical Staff Section (OMSS) approve amending the MSMS Hospital Medical Staff Section (HMSS) Bylaws and recommend amendments to the MSMS Bylaws to reflect this change; and be it further

RESOLVED: That these changes to the MSMS/HMSS Bylaws and the recommended amendments to the MSMS Bylaws be considered during, and if approved, take immediate effect at the 1997 MSMS House of Delegates meeting.

RESOLUTION 6-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Common Physician Credentialing Form. APPROVED.

RESOLVED: That MSMS endorse and support the efforts of Michigan Physicians Credentialing Verification Service (MPCVS) in developing and/or coordinating the development of common community physician credentialing applications; and be it further

RESOLVED: That MSMS encourage hospitals and managed care organizations to utilize the services of MPCVS.

MSMS Speaker Dorothy Kahkonen, MD, left, enjoys a moment of House debate while Vice Speaker Paul O. Farr, MD, takes his turn at the podium.



The difficult topic of physician assisted suicide and the MSMS position on the procedure drew long lines of delegates to testify at the microphone.





Thomas C. George, MD, Kalamazoo, drew much praise for his judicious handling of the debate on physician assisted suicide. He chaired Reference committee C-Internal Affairs, at the House of Delegates Meeting.

RESOLUTION 7-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title:Corporate Affiliated Physicians Reimbursement. ADOPTED AS AMENDED.

RESOLVED: That MSMS encourage all corporate affiliated physicians to be prospectively involved in the health and hospital negotiations for capitation and global billing contracts; and be it further

RESOLVED: That MSMS encourage health and hospital organizations to inform the corporate affiliated physicians regarding the actual fee which is the physician component of the contractual arrangement; and be it further

RESOLVED: That MSMS encourage the Michigan Health and Hospital Association (MHA) to recommend to its membership that corporate affiliated physicians be prospectively involved in negotiations for contractual arrangement.

RESOLUTION 8-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: State Licensing Board Requirements for Temporary Licenses. NO ACTION.

RESOLUTION 9-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Reduction of Privileges Because of Activities Unrelated to Medical Practice. ADOPTED.

RESOLVED: That MSMS condemn any action taken by hospital administrations and/or boards of directors to reduce or withdraw privileges of a medical staff member based on activities unrelated to professional competence, conduct, or ethics.

RESOLUTION 10-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Development of Guidelines for Medical Staff Participation. ADOPTED AS AMENDED.

RESOLVED: That MSMS continue to study the impact of hospital affiliations and mergers on their respective medical staff organizations and their members report to the OMSS Governing Council at its 1998 annual meeting.

RESOLUTION 11-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Elimination of Medical Staff Membership/Privileges as a Required Qualification for Participation in a Managed Care Contract Panel. APPROVED.

RESOLVED: That MSMS advise managed care organizations to eliminate the requirement of medical staff membership and privileges for physicians to participate in managed care contract panels as long as the organization has in place a process for providing continuity of care; and be it further

RESOLVED: That MSMS ask Michigan Physicians

Credentialing Verification Service (MPCVS) to credential physicians who do not maintain medical staff membership/privileges.

RESOLUTION 12-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Qualifications for Position: Chief of the Medical Staff. ADOPTED.

RESOLVED: That MSMS reaffirm the policy that an organized medical staff is an autonomous body responsible for establishing a candidate slate and electing its own officers; and be it further

RESOLVED: That MSMS encourage medical staffs to include in their bylaws a provision that all physicians be eligible for election to chief of staff unless the physician serves in a major medical administrative position at the hospital.

RESOLUTION 13-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Labeling of All Foods Containing L-Glutamic Acid. APPROVED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek a mandate for labeling all foods containing even small amounts of free glutamic acid, stating on the label, in milligrams, the amount of free glutamic acid present, identified as monosodium glutamate (MSG), so that individuals may know the amount of MSG present and may avoid any amount of MSG.

RESOLUTION 14-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: The Responsibility of Managed Care Organizations to Explain Health Care Contracts. ADOPTED AS AMENDED.

RESOLVED: That MSMS seek legislation to require all health insurance and managed care plans to explain honestly, and in clear and familiar terms, all pertinent information about the health plan to prospective purchasers and enrollees.

RESOLUTION 15-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Physician Organizations/Physician Hospital Organizations (POs/PHOs), Michigan Medical Advantage (MMA) Cooperation. APPROVED.

RESOLVED: That MSMS encourage Physician Organizations/ Physician Hospital Organizations (POs/PHOs), to cooperate with Michigan Medical Advantage (MMA) in developing strategies to encourage cost-effective outsourcing of some services and assistance programs for development of PO/PHO revenue sources, management oversight and review programs for POs/ PHOs.

RESOLUTION 16-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Aging of Surgical Claims by Third Party Carriers. ADOPTED AS AMENDED.

RESOLVED: That MSMS review with third party carriers the inordinate aging of claims and request prompt and timely payment of such claims within 30 days or transfer such monies into the physician's escrow account.

RESOLUTION 17-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Managed Care Contracts. NO ACTION.

RESOLUTION 18-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Health Care Financing Administration (HCFA) Blood Test Policies. Substitute Resolution (in lieu of Resolutions 2-97A and 18-97A) See Resolution 2-97A. ADOPTED.

RESOLUTION 19-97A

John A. Rupke, MD, for the Organized Medical Staff Section Title: Profession Review Organization Peer Review. ADOPTED AS AMENDED.

RESOLVED: That MSMS strongly recommend that any professional review organization accept national medical specialty society guidelines or parameters for its review process, where they exist; and be it further

RESOLVED: That all critiques shall be by peers in the same specialty; and be it further

RESOLVED: That the Michigan Delegation to the AMA refer this resolution to the AMA for its consideration and utilization in all states.

RESOLUTION 20-97A

Doyle E. Calley, MD, Ionia-Montcalm County Title: MSMS to Evaluate Health Insurance Products. RE-FERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS set up a mechanism to evaluate health insurance products in terms of quality of care, patient satisfaction, provider satisfaction, and ratio of administrative cost to total health care dollars spent.

RESOLUTION 21-97A

Narinder K. Sherma, MD, Wayne County Title: Health Insurance Service. REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS develop a service for our patients and their health insurance contract negotiators to clearly understand the health insurance contracts offered to them.

RESOLUTION 22-97A

James P. Gallagher, MD, for the Wayne County Delegation

Title: Immunity From Civil or Criminal Liability for Reporting Suspected Acts of

Domestic Violence. Reaffirmed Existing Policy. (Although already current policy the committee received positive testimony and wished to further endorse the intent of the resolution)

RESOLVED: That MSMS seek legislation to enact a law that will provide immunity to any health care provider who, in good faith, makes a report to law enforcement agencies regarding a suspected case of domestic violence inflicted on an adult.

RESOLUTION 23-97A

Susan H. Adelman, MD, for the Wayne County Delegation Title: Hospital Billing on Behalf of Physicians. ADOPTED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to study and report back on the amount of physician billings that hospitals typically fail to collect; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to study and report back on the accuracy of hospital billing and coding on behalf of physicians.

RESOLUTION 24-97A

James P. Gallagher, MD, for the Wayne County Delegation Title: No Cardio Pulmonary Resuscitation (CPR) Orders in Adult Foster Care and Assisted Living Settings. ADOPTED AS AMENDED.

RESOLVED: That MSMS work with the Department of Consumer and Industry Services to implement the current laws governing a Do-Not-Resuscitate order for residents of adult foster care facilities, as delineated in P.A. 218 of 1979 (Adult Foster Care Facility Licensing Act) and revisions made in Acts 192, 193 and 194 of Public Acts of 1996; and be it further

RESOLVED: That MSMS, through the Committee on Aging, continue investigating current policies/laws applying to Do-Not-Resuscitate orders as well as other advanced directives for health care concerning residents of nursing homes, adult foster care facilities and other non-hospital settings.

RESOLUTION 25-97A

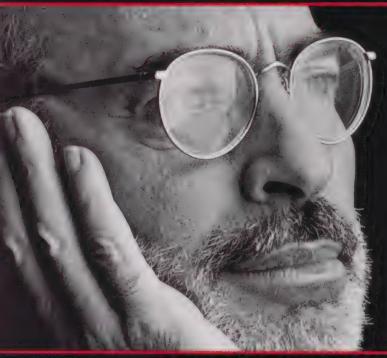
Susan H. Adelman, MD, for the Wayne County Delegation Title: Dues. Adopted as Amended.

RESOLVED: That MSMS make a major organizational effort to persuade physicians' employers to allocate at least \$2,000 as a professional development allowance, of which \$1,300 can only be spent on county, state and AMA dues; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to make a major organizational effort to persuade physicians' employers to allocate at least \$2,000 as a professional development allowance, of which \$1,300 can only be spent on county, state and AMA dues.

In hypertension

HE KNOWS THE PROOF IS IN THE PERFORMANCE



THAT'S WHY HE PRESCRIBES ADALAT CC

Efficacy comparable to Procardia XL®1.2 and Norvasc®*3.4

Similar safety profile[†] to Procardia XL^{1,3} and Norvasc^{3,4}

Substantially lower cost than Procardia XL and Norvasc‡5

Once-A-Day



30mg, 60mg & 90mg

A PRACTICAL CHOICE

Adalat CC is not indicated for angina. It should be taken on an empty stomach. As with all distinct pharmacologic entities, switching from one to another may necessitate careful titration and patient monitoring.

*Procardia XL (nifedipine) and Norvasc (amlodipine besylate) are registered trademarks of Pfizer Labs Division, Pfizer Inc.

*Frequency and type of side effects are typical of dihydropyridine calcium channel blockers.6

‡Calculations based on suggested Average Wholesale Price (AWP).⁵ AWP is from a published price list and may or may not represent the actual price to pharmacists or consumers.

Please see brief summary of Prescribing Information on following page.



30mg, 60mg & 90mg

A PRACTICAL CHOICE

BRIEF SUMMARY CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION For Oral Use

INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hyperten-

sion. It may be used alone or in combination with other antihypertensive agents CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: Excessive Hypotension: Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial intration or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomitant beta-diockers.

Severe hypotension and/or increased fluid volume requirements have been reported in maintain two records dispending the patients with a facility to the patients where the propriet in the contraction and contract the patient was recorded immediated above considerations.

Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release cappules together with a bett-blacking agent and who underwent coronary artery byposs surgery using high dose fentanyl anesthesis. The interaction with high dose fentanyl appears to be due to the combination of nifedipine and a beta-blacker, but the possibility that it may occur with nifedipine alone, with low doses of fentanyl, in other surgical procedures, or with other ancroic analysis cannot be ruled out. In nifedipine-tereated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (of least 36 hours) should be allowed for nifedipine to be worshed out of the body prior to surgery.

snoula de allowed for intelligine to de wostele out of me bood prior to surgery.

Increased Angine and/or Myocardial Infarction: Rorely, patients, particularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angine or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beta-Blocker Withdrawal: When discontinuing a beta-blocker it is important to taper its dose, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of infedipine angina, producy remote to increased sensitivity to categoratines. Intimation of ritineganite treatment will only prevent this occurrence and on accision has been reported to increase it.

Congestive Heart Failure: Rarely, patients (usually while receiving a beta-blocker) have developed heart failure after beginning infedigine. Patients with light barris stensis may be at greater risk for such on event, as the unloading effect of infedigine would be expected to be of less benefit to these patients, owing to their fixed impedance to

Thow dross the confict ravie.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vas-cular resistance, careful monitoring of blood pressure during the initial administration and titration of ADALAT CC is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See WARNINGS).

already taking meditations that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dos-edependent manner with ADALAT CC. The placebo subtracted rate is approximately 8% at 30 mg, 12% at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought to be associated with vasodiation of dependent arterioles and small blood vessels and not due to left ventricular drysfunction or generalized fluid retention. With patients whose hypertension is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction. Information for Patients: ADALAT CC is an extended release tablet and should be swallowed whole and taken on an empty stomach. It should not be administered with food. Do not chew, divide or crush tablets.

trodu. On not ricky, drivide or crush tablets.

Labbaratory Testss: Rare, usually transient, but occasionally significant elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted. The relationship to mifedipine therapy is uncertain in most case, but probable in some. These laboratory obnormalities have rarely been associated with clinical symptoms; however, cholestasis with or without joundate has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT (C. This was an isolated finding and it reray! resulted in volues which fell outside the normal range. Rare instances of allergic hepatitis have been reported with mideligine treatment. In controlled studies, ADALAT (C did not adversely affect serum uric acid, glucose, cholesteral or potassium.

ADALAT CC did not adversely affect serum uric acid, glucose, cholesteral or potassium. Nifedipine, like other calcium channel blockers, decreases platelet aggregation in vitra. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding, time in some ritedipine potients. This is thought to be a function of inhibition of calcium transport across the platelet membrane. No clinical significance for these findings has been demonstrated. Positive direct Coombs' test with a row without hemolytic anomain has been reported but a causal relationship between rifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although rifieldpine has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to nifedipine therapy is uncertain in most cases but probable in some.

Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been orcasional literature reports suggesting that the combination of nitedipine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of angina in patients with cardiovascular disease. Digitalis: Since there have been isolated reports of patients with elevated digoxin levels, and there is a possible interaction between digoxin and ADALAT CC, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalizations.

Coumarin Anticoagulants: There have been rare reports of increased prothrombin time in patients taking coumarin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quintidine: There have been rore reports of an interaction between quintidine and nifedipine (with a decreased plasma level of quintidine).

Cimeridine: Both the peak plasma level of nifedipine and the AUC may increase in the pres-

Camerianies und mit peacy passand verve or interquine dual net Auc may in Article at mit a pre-ence of cimerialine. Rontificine produces smaller non-significant increases. This effect of cime-lidine may be mediated by its known inhibition of hepatic cytochrome P-450, the enzyme system produbly responsible for the first-poss methodols mol nitedipline. If intelligine thera-py is initiated in a patient currently receiving cimeridine, coutious filtration is advised.

py is initiated in a patient currently receiving cimeridine, coulious filtration is odvised.

Carcinagenesis, Mutagenesis, impairment of Ferlilly: Nitrelighne was administered arally to rats for two years and was not shown to be carcinagenic. When given to rats prior to mating, nitreligine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo mutagenicity studies were negative.

Pregnancy: Pregnancy Category C. In rodents, rabbits and monkeys, nifedipine has been shown to have a variety of embryotaxic, placentoxix: and effoctionic effects, including stunted fetuses (rost, mice and robbits), digital anomalies (rots and rabbits), rib deformities (mice), cleft polate (mice), small placentos and underdeveloped chorionic villi (monkeys), embryonic and fetal deaths (rots, mice and robbits), profunged encival (rats); not evaluated in other species), and decreased neonatal survival (tasts; not evaluated in other species). On a mg/kg or mg/m² bosis, some of the doses associated with these various effects are higher than the maximum recommended human dose and some are lower, but all are within an order of magnitude of it.

The digital anomalies seen in infeligitine-exposed robbit pugs are strikingly similar to

The digital anomalies seen in infedipine-exposed robbit pups are strikingly similar to those seen in pups exposed to phenytoin, and these are in turn similar to the phalangeal deformities that are the most common malformation seen in human children with in utera exposure to phenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the letus.

Nursing Mothers: Nifedipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

importance of the arry to the mother.

ADVERSE EXPERIENCES: The inridence of adverse events during treatment with ADALAT CC in doses up to 90 mg daily were derived from multi-center placebo-controlled clinical trials in 370 hypertensive patients. Alenold 50 mg once daily was used concominantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo. All adverse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

The most common adverse event reported with ADALAT® CC was peripheral edema. This was dose related and the frequency was 18% on ADALAT CC 30 mg daily, 22% on ADALAT CC 60 mg daily on 29% on ADALAT CC 90 mg daily versus 10% on placebo.

ADMACH CC 60 mig daily on a 27% oil machair CC 90 mig anny Versias 17% on placebo.

Other common odverse events reported in the obove placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Flusian (2%, versus 1% placebo incidence); Goustian (2%, versus 1% placebo incidence); Goustian (1%, versus 1% placebo incidence); Goustian (1%, versus 1% placebo incidence); Onstipation (1%, versus 0% placebo incidence).

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90 mg:

Body as a Whole/Systemic: chest pain, leg pain Central Nervous System: paresthesia, vertigo Dermatologic: rash Gastrointestinal: constipation Musculoskeletal: leg cramps Respiratory: epistaxis, rhinitis Uragenital: impotence, urinary frequency

ted with an incidence of less than 1.0% were

Other adverse events reported with an incidence of less than 1.0% were:

Body as a Whole/Systemic cellulitis, chills, facial edema, neck pain, pelvic pain,
pain Cardiovascular: atrial fibrillation, bradycardia, cardiac arrest, extrasystole,
hypotension, polipitations, phiebitis, postural hypotension, tachycardia, cutoneous angiectaese Central Nerveus Systems anxiety, confusion, decreased libido, depression,
hypertonia, insamnia, somnolence Dermatologic: pruritus, sweating
Gastroiatestinal: abdominal pain, diarrhea, dry mouth, dyspepsia, esophaglis, flatuence, gastrointestinal hemorrhage, vomiting. Hematologic: lymphadenopathy
Metabolic: gout, weight loss Musculoskeletal: arthrafqia, ortifinitis, myalgia
Respiratory: dyspnea, increased cough, rales, pharyngitis Special Senses: abnormal vision, amblyopia, conjunctivitis, diplopia, timitus Uragenital/Reproductive:
kidney calculus, nocturio, breast engargement

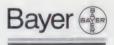
The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergenic hepatitis, alopecia, anemia, arthritis with MM (+), depression, erythromelalgia, exfoliative dermatitis, fever, gingival hyperplasia, gynecomastia, leukopenia, mood changes, muscle cramps, nervousness, paranaid syndrome, purpurur, shokiness, sleep disturbances, syncope, laste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urticaria.

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1. Glasser SP, Ripa SR, Allenby KS, Schwartz LA, Commins BM, Jungerwirth S, on behalf of the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine Administered without Food: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Hypertension. Clin Ther. 1995;17(2):296-312. **2.** Glasser SP, Jain A. Allenby KS, Shannon T, Pride K, Pettis PP, Schwartz L. MacCarthy EP, and the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation Gastrontestunal Therapeutic System Formulation in Patients with Mild-to-Moderate Diastolic Hypertension. Clin Ther. 1995;17(1):12-29.

3. Data on file. Bayer Corporation, Pharmaceutical Division.

4. Zidek W. Spiecker C. Knaup G. Steindl L. Breuer H-W. on behalf of the Hypertension Study Group. Comparison of the Efficacy and Safety of Nifedipine Coat-Core Versus Ambodipine in the Treatment of Patients with Mild-to-Moderate Essential Hypertension. Clin Ther. 1995;17(4):686-700. **5.** Redbook Update. Montvale, NJ, Medical Economics Data, Inc., December 1996 6. Adalat² CC Product Monograph, April 1995.



Pharmaceutical Division

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RESOLUTION 26-97A

Robert P. Lilly, MD, for the Wayne County Delegation Title: Davis Rules of Order, APPROVED.

RESOLVED: That MSMS provide each member of the MSMS House of Delegates with either an explanation of the differences between the Davis and Roberts Rules of Order, or a summary of the Davis Rules and Order.

RESOLUTION 27-97A

James P. Gallagher, MD, for the Wayne County Delegation Title: Headlight Vehicle Legislation. NO ACTION.

RESOLUTION 28-97A

Robert P. Lilly, MD, for the Wayne County Delegation Title: MSMS Constitution and Bylaws Description for Delegates. NO ACTION.

RESOLUTION 29-97A

Gilbert B. Bluhm, MD, for the Wayne County Delegation Title: Utilization Review is the Practice of Medicine. ADOPTED AS AMENDED.

RESOLVED: That MSMS pursue appropriate measures, including legislation, to declare that only licensed practicing physicians in the same specialty may perform utilization review for health plans.

RESOLUTION 30-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: MSMS Secretary and Treasurer. Substitute Board Action Report #8 (in lieu of Board Action Report #8, Resolutions 30-97A and 31-97A) SEE BOARD ACTION RE-PORT #8.

RESOLUTION 31-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: MSMS Assistant Secretary and Assistant Treasurer. Substitute Board Action Report #8 (in lieu of Board Action Report #8, Resolutions 30-97A and 31-97A). SEE **BOARD ACTION REPORT #8.**

RESOLUTION 32-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: Abolition of Wayne and Outstate Caucuses. NO AC-TION.

RESOLUTION 33-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: Establishment of an Advisory Council to the MSMS Board of Directors. NO ACTION.

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RESOLUTION 34-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: Notification of Open and Expiring MSMS Positions. APPROVED.

RESOLVED: That MSMS inform all county and component medical societies about open and expiring MSMS positions and offices following the mid-summer MSMS Board of Directors meeting in the preceding calendar year, including notification in Medigram.

RESOLUTION 35-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: Removal of Tobacco Stocks From MSMS Portfolio. APPROVED.

RESOLVED: That the stocks of tobacco companies should be removed from the portfolio of MSMS holdings.

RESOLUTION 36-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: MSMS Community Service Awards Presentation. ADOPTED AS AMENDED.

RESOLVED: That MSMS recognize the recipients of the MSMS Community Service Awards by reading their names at the annual MSMS House of Delegates meeting, and giving recognition at the local level.

RESOLUTION 37-97A

Michael W. Smith, MD, for the Washtenaw County Delega-

Title: Availability of Information and Reports to the MSMS Board of Directors. NO ACTION.

RESOLUTION 38-97A

Peter S. Chang, MD, for the Young Physicians Section Title: Practice Management Information. ADOPTED AS AMENDED.

RESOLVED: That MSMS promote the availability of, and help disseminate, practice management information and services, using all available communications media, including electronic, with special notice to young physicians and newly practicing physicians of materials helpful to them; and be it further

RESOLVED: That MSMS compile a list of practice management resources available for members in coordination with Michigan Medical Advantage.

RESOLUTION 39-97A

Peter S. Chang, MD, for the Young Physicians Section Title: Young Physicians Section (YPS) Newsletter/Communications. APPROVED.

RESOLVED: That MSMS develop a newsletter distinctly for young physicians that can be disseminated to young physician members which discusses activities and issues of importance to young physicians; and be it further

RESOLVED: That MSMS make available a MSMS Young Physicians Section (YPS) newsletter electronically.

RESOLUTION 40-97A

Peter S. Chang, MD, for the Young Physicians Section Title: Term Limits for the Michigan Delegation to the AMA. NO ACTION.

RESOLUTION 41-97A

Peter S. Chang, MD, for the Young Physicians Section Title: MSMS Section on Group Practice. NOT ADOPTED.

RESOLUTION 42-97A

Peter S. Chang, MD, for the Young Physicians Section Title: Tax Deductions for Those Who Provide Indigent Care. NO ACTION.

RESOLUTION 43-97A

Peter S. Chang, MD, for the Young Physicians Section Title: The Study of Alternative Medicine. ADOPTED AS AMENDED.

RESOLVED: That MSMS use existing communications vehicles to report about resources on alternative medicine including profiles of legitimate Michigan medical practitioners using alternative therapies particularly as they relate to chronic diseases.

RESOLUTION 44-97A

Peter S. Chang, MD, for the Young Physicians Section Title: MSMS Support for Prudent Lay Person Legislation. APPROVED.

RESOLVED: That MSMS fully support and endorse House Bill 4080, Prudent Lay Person Legislation and testify before the appropriate legislative committees.

RESOLUTION 45-97A

Peter S. Chang, MD, for the Young Physicians Section Title: Young Physicians Section (YPS) Representation on the Michigan Delegation to the AMA. REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS create one Young Physician Section (YPS) Delegate and one YPS Alternate Delegate position on the MSMS Delegation to the AMA.

RESOLUTION 46-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Increasing International Medical Graduates' (IMGs) Membership in MSMS and the AMA International Medical Graduates (IMGs) Sections. APPROVED.

RESOLVED: That MSMS provide a cogent, detailed and visible synopsis of the Section's successes; and be it further

RESOLVED: That MSMS create an event during which IMGs have an opportunity to discuss how to enhance IMG Section growth.

RESOLUTION 47-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Clarifying AMA Policy on Residency Selection, Substitute Resolution (in lieu of 47-97A and 54-97A). ADOPTED.

RESOLVED: That MSMS take action to reaffirm existing policy that admission to residency training shall be based upon the merit of the applicant without regard to race, color, creed and country of original medical training when such an applicant has satisfied all current legal and regulatory requirements for medical practice in the United States of America; and be it

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to reaffirm the AMA policy that requires the selection of those to fill residency positions based on the merit of the applicant without regard to race, color, creed and country of medical training when such an applicant has satisfied all current legal and regulatory requirements for medical practice in the United States; and be it further

RESOLVED: That the Michigan Delegation to the AMA urge the AMA Board of Trustees to act in the interests of all AMA members.

RESOLUTION 48-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title:Include "Country of Medical Education" in AMA's Proposed Patient Protection Act and Proposed Fairness in Health Care Act. APPROVED.

RESOLVED: That the Michigan Delegation to the AMA request the AMA to insert "country of medical education" in all appropriate locations in each of the components of the proposed Patient Protection Act, including the proposed Fairness in Health Care Act.

RESOLUTION 49-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Request the AMA to Encourage International Medical Graduate (IMG) Sections at All State Medical Associations, APPROVED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to undertake a program of actively supporting the

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creation of International Medical Graduates (IMGs) Sections at all state medical associations, and especially those with high concentrations of IMGs.

RESOLUTION 50-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: MSMS Nominate Busharat Ahmad, MD, to Initial Governing Council of the AMA's International Medical Graduate (IMG) Section. APPROVED.

RESOLVED: That MSMS nominate Busharat Ahmad, MD, to the initial Governing Council of the AMA's International Medical Graduates (IMG) Section for the one year appointment that has been authorized by the AMA House of Delegates when nominations are called for; and be it further

RESOLVED: That MSMS attempt, by all appropriate means, to assure that an appointment to this Governing Council occurs.

RESOLUTION 51-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Ban on Land Mines. APPROVED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to work with the U.S. mission at the United Nations to ban the manufacturing, trade and use of all land mines.

RESOLUTION 52-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: International Medical Graduate (IMG) Community Service Award. DISAPPROVED.

RESOLUTION 53-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Establish the Number of Graduate Medical Education Positions to Fit the Needs of the USA. Substitute Resolution, ADOPTED,

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to establish the appropriate number of graduate medical education positions to fit the need of this country.

RESOLUTION 54-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Consensus Statement on the Physician Work Force. Substitute Resolution (in lieu of Resolutions 47-97A and 54-97A). See Resolution 47-97A. ADOPTED.

RESOLUTION 55-97A

Allan C. D. Brown, MD, for the Section for International Medical Graduates

Title: Require Mandatory Immunizations Coverage for Insurance Companies. ADOPTED AS AMENDED.

Reference Committee Personnel

These 67 physicians debated and studied 118 resolutions and 12 Board reports referred to the House of Delegates.

Reference Committee A - Medical **Care Delivery**

Brian R. McCardel, MD, Chair, Ingham Carol A. Kreig, MD, Delta Michael A. Sandler, MD, Wayne Jagdish K. Shah, MD, Genesee Linda K. Stanley, MD, Berrien Richard H. Wakulat, MD, MI Society of Internal Medicine

James D. Webb, MD, Newaygo

William H. Woodhams, MD, Kalamazoo

Board Advisors:

Richard P. Horsch, MD John M. MacKeigan, MD James E. McGillicuddy, MD

AMA Delegation Advisors:

Susan H. Adelman, MD Alan M. Mindlin, MD

Staff:

Mary Anne Ford Julie L. Lester Joyce A. Nurenberg

Reference Committee B - Legislation

Inad Haddad, MD, Chair, Lenawee laime V. Aragones, MD, Oakland Cheryl Davison, MD, Marquette Joseph E. Kincaid, MD, Kalamazoo Vivian M. Lewis, MD, Genesee Moses Muzquiz, MD, Jackson Michael J. Parks, MD, Hillsdale Gregory L. Walker, MD, MI Chapter, American College of Emergency Phy-

Board Advisors: Mark D. Kolins, MD Cecil R. Jonas, MD Frederick V. Minkow, MD **AMA Delegation Advisors:** Cathy O. Blight, MD Thomas C. Payne, MD Thomas E. Stone, MD Staff:

Gregory T. Aronin Bryce W. A. Docherty Donna W. LaGosh

Reference Committee C - Internal Affairs and Public Service

Thomas M. George, MD, Chair, Kalamazoo Tama D. Abel, MD, Washtenaw Edward C. Bush, MD, Wayne Karyn E. Gell, MD, Kent

Omero S. Iung, MD, Ingham Peter T. Muller, MD, Oakland

Dennis C. Szymanski, MD, Berrien

Allen F. Turcke, MD, Genesee

Board Advisors:

James B. Kilway, MD John H. McLaughlin, MD David J. Millard, MD

AMA Delegation Advisors:

Busharat Ahmad, MD Carl F. Hammerstrom, MD

Staff:

David K. Fox Sheri W. Greenhoe Thomas M. Seely

RESOLVED: That MSMS support legislation at state and federal levels to require all insurance companies to cover all recommended immunizations. In the absence of such legislation that MSMS pursue other avenues to encourage insurers to offer immunization coverage in their health policies.

RESOLUTION 56-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: New Membership Category. NO ACTION.

RESOLUTION 57-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: Managed Care and Medical Education Funding. RE-FERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS seek medical education funding through managed care organization payments to hospitals.

RESOLUTION 58-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: Routine Premarital HIV Testing. ADOPTED AS AMENDED.

RESOLVED: That MSMS make required premarital HIV testing policy; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to make required premarital HIV testing policy.

RESOLUTION 59-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: Physician Assistants (PAs) and Controlled Substances. APPROVED.

RESOLVED: That MSMS investigate changes in Board of Medicine administrative rules so the Physician Assistants (PAs) can write orders for controlled substances in the hospital setting upon verbal order of his or her collaborating physician; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to investigate changes nationwide regarding Physician Assistants so the Physician Assistants (PAs) can write orders for controlled substances in the hospital setting upon verbal order of his or her collaborating physician.

RESOLUTION 60-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: Phillip Morris and Marketing Teens and Young Adults. APPROVED.

RESOLVED: That MSMS seek legislation that would make the distribution of cigarettes with other products illegal in Michigan; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek legislation that would make the distribution of cigarettes with other products illegal on a national level.

Reference Committee D - Physician Hospital Relations

Robert C. Packer, MD, Chair, Muskegon Owen M. Berow, MD, Kalamazoo Edwin H. Gullekson, MD, Genesee Samuel D. Indenbaum, MD. Wavne William H. McNamara, MD, North Cen-

Ann M. Minnema, MD, Kent Timothy D. Oliver, MD, Shiawassee Phillip B. Storm, MD, Ingham

Board Advisors

Rudi Ansbacher, MD

Kenneth H. Musson, MD Devendra K. Sharma, MD

AMA Delegation Advisors:

John W. Hall, MD

Marguerite R. Shearer, MD

Staff:

F. B. "Tom" Plasman Dawn M. Reha

Reference Committee E - Public Health

Kamran S. Moghissi, MD, Chair, Wayne Carolyn W. Bird, MD, Oakland David K. Johnson, MD, Ingham David C. Nolan, MD, Mecosta Richard H. Schiappacasse, MD, Macomb Richard C. Schultz, MD, Grand Traverse Robert M. Soderstrom, MD, Genesee Ianice L. Werbinski, MD, Kalamazoo **Board Advisors:**

T. Anthony Egleston, MD Jaak M. Pahn, MD Joseph J. Weiss, MD

AMA Delegation Advisors:

Domenic R. Federico, MD B. David Wilson, MD

Staff:

Christine N. Shearer Deborah Zannoth

Reference Committee F - Scientific and Educational Affairs

Michael W. Smith, MD, Chair, Washtenaw

Clyde R. Flory, MD, MI Allergy and Asthma Society

Melvin L. Hollowell, MD, Wayne

Partha S. Nandi, MD, Resident Section

John R. Petrasky, MD, Association of Public Health Physicians

Caroline G. M. Scott, MD, Saginaw

Kathleen J. Yost, MD, Kent

Board Advisors:

Joseph M. Beals, MD

David H. Gilbert, MD Jeffrey M. Jones, MD

AMA Delegation Advisors:

Gilbert B. Bluhm, MD

Rhoda M. Powsner, MD

Staff:

Judith E. Marr Colleen M. Horton

RESOLUTION 61-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: HIV Blood Test Without Informed Consent. Reaffirmed Existing Policy. (Current AMA and MSMS policy but the Committee wanted to record their support of this issue.)

RESOLVED: That MSMS adopt a policy that HIV testing no longer require informed consent with safeguards to protect the confidentiality of HIV test results; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to adopt a policy that HIV testing no longer require informed consent with safeguards to protect the confidentiality of HIV test results.

RESOLUTION 62-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: Safety of Great Lakes Fish. ADOPTED AS AMENDED.

RESOLVED: That MSMS request from Governor Engler and the Michigan Environmental Science Board scientific evidence regarding the Environmental Protection Agency's recommendations relative to the dangers of Great Lakes fish consumption.

RESOLUTION 63-97A

Domenic R. Federico, MD, for the Kent County Delegation

Title: Required Physician Visits for a Patient in Seclusion or Restraints. ADOPTED AS AMENDED.

RESOLVED: That MSMS seek revisions to the Mental Health Code so that assessment and management of hospitalized patient's in seclusion or restraints require no more than once daily face-to-face assessment by the patient's physician unless individual conditions warrant additional visits.

RESOLUTION 64-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: Evaluation of Managed Care as a Replacement to our Worker's Compensation System. ADOPTED AS AMENDED.

RESOLVED: That MSMS, through existing committees, study the pros and cons of changing our worker's compensation system to a managed care model.

RESOLUTION 65-97A

Domenic R. Federico, MD, for the Kent County Delegation Title: Peer Review Protection for Physician Organizations (POs) and Group Practices. APPROVED.

RESOLVED: That MSMS seek legislation that would give physician organizations (POs) and group practices peer review the same protection afforded hospital medical staff peer review, and state and county (local) medical societies; and be it further

Reference Committee on Credentials and Tellers

Charles J. Heyka, MD, Chair, Northern Michigan

Frederick B. Brown, MD, Muskegon Vickers C. Hansen, MD, Manistee Allan L. Olson, DO, Marquette-Alger Peter Sneed, MD, Grand Traverse Staff:

Kathy M. Hagen

Committee on Constitution and Bylaws

Lourdes V. Andaya, MD, Chair, Wayne R. Paul Clodfelder, MD, Kent Richard P. Heuschele, MD, Saginaw Carl VanAppledorn, MD, Washtenaw Geoffrey A. Wardwell, MD, Kalamazoo Ex officio Members: Dorothy M. Kahkonen, MD William E. Madigan, Executive Director Willard S. Stawski, MD Richard D. Weber, Legal Counsel

Reference Committee on Rules and Order of Business

Thomas J. Zuber, MD, Chair, Midland Richard D. Bates, MD, Alpena Edward N. Johnson, MD, Chippewa-Mackinaw

Ex officio Members:

Thomas R. Berglund, MD Dorothy M. Kahkonen, MD Paul O. Farr, MD

Staff:

Donna L. Brown Jeanne K. Miller

Reference Committee on Ways and Means

Alan M. Mindlin, MD, Chair, Oakland Donald H. Batts, MD, Kalamazoo Carlo A. Dall'Olmo, MD, Genesee Kory V. Deason, MD, Eaton AppaRao Mukkamala, MD, Genesee Jack L. Romence, MD, Kent

Board Advisors:

Hassan Amirikia, MD Billy Ben Baumann, MD David Moore Hislop, MD Earl G. Moehn, MD Staff: Paula A. Richardson Jerome F. Trahan

Staff: Irene J. Frost RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek legislation that would give physician organizations (POs) and group practices peer review the same protection afforded hospital medical staff peer review, and state and county (local) medical societies.

RESOLUTION 66-97A

Thomas M. George, MD, Kalamazoo County

Title: Medical Direction of Advanced Practice Nurses. RE-FERRED TO THE BOARD FOR STUDY AND ACTION.

RESOLVED: That MSMS seek legislation requiring supervision of advanced practice nurses by physicians of the appropriate specialty.

RESOLUTION 67-97A

Allan L. Olson, MD, Marquette County

Title: Task Force to Simplify Current Healthcare Delivery System and Improve Access to Care. NO ACTION.

RESOLUTION 68-97A

Cheryl Davison, MD, Marquette County for John W. English,

Title: Physician Assisted Suicide. Substitute Resolution (in lieu of Resolutions 68-97A and 85-97A). ADOPTED.

RESOLVED: That MSMS adopt the position of the American Medical Association on physician assisted suicide which states:

"Physician assisted suicide occurs when a physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress, such as those suffering from a terminal, painful, debilitating illness, may come to decide that death is preferable to life. However, allowing physicians to participate in assisted suicide would cause more harm than good. Physician assisted suicide is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of participating in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Patients should not be abandoned once it is determined that cure is impossible. Patients near the end of life must continue to receive emotional support, comfort care, adequate pain control, respect for patient autonomy, and good communication."

RESOLUTION 69-97A

David K. Johnson, MD, Ingham County, for Gregory G. Messenger, MD and Floyd G. Goodman, MD

Title: MSMS Support Freestanding Ambulatory Surgery Centers. DISAPPROVED.

RESOLUTION 70-97A

David K. Johnson, MD, Ingham County, for Gregory G. Messenger, MD, and Floyd G. Goodman, MD

Title: Failure of Blue Cross Blue Shield of Michigan (BCBSM) to Comply With Public Act 350, re: Reimbursement of Physician-Owned Freestanding Outpatient Surgical Centers. ADOPTED AS AMENDED.

RESOLVED: That MSMS pursue appropriate avenues to encourage Blue Cross Blue Shield of Michigan (BCBSM) to reimburse facility fees for services performed in state licensed and approved freestanding medical and surgical facilities.

RESOLUTION 71-97A

Robert S. Levine, MD, Oakland County Title: False 911 Calls. NO ACTION.

RESOLUTION 72-97A

Robert S. Levine, MD, for the Oakland County Delegation Title:Licensing of Cigarette Vendors. ADOPTED AS AMENDED.

RESOLVED: That MSMS seek and support annual state licensing of each and every tobacco product vending machine; and be it further

RESOLVED: That MSMS seek legislation requiring the licensing of all vendors of tobacco products; and be it further

RESOLVED: That MSMS seek legislation requiring the licensing of each and every tobacco product vending machine; and be it further

RESOLVED: That MSMS request legislation to require a minimum licensing fee of \$1,000 per year for each tobacco vending machine, and that the revenue from this licensing fee be used to support tobacco education programs and enforcement of such legislation.

RESOLUTION 73-97A

Robert S. Levine, MD, for the Oakland County Delegation Title: Mini Cigarette Packages. APPROVED.

RESOLVED: That MSMS seek legislation that the State of Michigan would prohibit the sale of cigarettes in packages containing less than twenty (20) cigarettes and/or in packages that can be broken into units that contain fewer than twenty (20) cigarettes.

RESOLUTION 74-97A

Robert S. Levine, MD, for the Oakland County Delegation Title:Independent Medical Examiners Specialty. DISAP-PROVED.

RESOLUTION 75-97A

Robert S. Levine, MD, for the Oakland County Delegation Title: Do Not Resuscitate (DNR) Orders on Drivers Licenses. DISAPPROVED.

RESOLUTION 76-97A

Jaime V. Aragones, MD, for the Oakland County Delegation Title: Mandatory Referral for Failed Visual Screening Levels. REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS seek legislation mandating referral to ophthalmologists (MD or DO) of all Michigan drivers license applicants with a visual acuity less than 20/40 best corrected vision in either eye, unless their visual loss has had prior documentation.

RESOLUTION 77-97A

Alan M. Mindlin, MD, Oakland County, for the MSMS Alli-

Title: Requirement for Marriage Licenses. APPROVED.

RESOLVED: That MSMS support the efforts of the MSMS Alliance in its legislative initiative which seeks to add the words "This is a License to Marry, Not to Abuse" to Michigan marriage licenses.

RESOLUTION 78-97A

Harvey W. Halberstadt, MD, for the Oakland County Delega-

Title: Board Certification and Managed Care. NOT ADOPTED.

RESOLUTION 79-97A

Joseph A. Arena, Jr., MD Oakland County Title: Redefinition of Automobile Manufacturers' Responsibilities. ADOPTED AS AMENDED.

RESOLVED: That MSMS be the first in the nation to advise automobile manufacturers that their responsibilities to the public include the manufacture of safer vehicles.

RESOLUTION 80-97A

Janice L. Werbinski, MD, Kalamazoo County, for the Committee on Concerns of Women Physicians

Title: Childcare Provision at MSMS Functions. ADOPTED AS AMENDED.

RESOLVED: That MSMS arrange for childcare services on a fee-for-service basis at the MSMS House of Delegates and the Annual Scientific Meeting.

RESOLUTION 81-97A

Janice L. Werbinski, MD, Kalamazoo County, for the Committee on Concerns of Women Physicians

Title: Pay Equity. REFERRED TO THE BOARD FOR

RESOLVED: That the MSMS Board of Directors contract with a consulting firm to review payroll records and interview employees as necessary to assure this House of Delegates that MSMS is in full compliance with Equal Employment Opportunity Commission (EEOC) regulations and that MSMS is free of any discriminatory employment practices.

RESOLUTION 82-97A

Janice L. Werbinski, MD, Kalamazoo County, for the Committee on Concerns of Women Physicians

Title: Harassment Education. REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That a report be made to this House regarding what specific policies are in place and what specific actions have been taken to educate MSMS staff about harassment in the workplace.

RESOLUTION 83-97A

Janice L. Werbinski, MD, Kalamazoo County, for the Committee on Concerns of Women Physicians

Title: Availability of Commissioned Data. NO ACTION.

RESOLUTION 84-97A

Donald C. Camp, MD, MI Society of General Surgeons Title: Consultation Fees Reimbursed Separate from Procedure Fees. APPROVED.

RESOLVED: That MSMS affirm that consultations are services separate from any care rendered thereafter, and that consultation fees are legitimate charges in their own right, whether or not a procedure, with a fee, occurs afterward, and that consultations therefore should be reimbursed separately from procedure reimbursement.

RESOLUTION 85-97A

Louis R. Zako, MD, Northern Michigan

Title: Physician Assisted Suicide. Substitute Resolution (in lieu of Resolutions 68-97A and 85-97A). See Resolution 68-97A. ADOPTED.

RESOLUTION 86-97A

Allen F. Turcke, MD, for the Genesee County Delegation Title: 800 Number for MSMS Member Use. ADOPTED AS AMENDED.

RESOLVED: That MSMS establish, on a one year trial basis, an 800 or 888 number for member use in contacting MSMS staff members by phone and that it report back to the House on its usefulness and cost-effectiveness.

RESOLUTION 87-97A

Allen F. Turcke, MD, for the Genesee County Delegation Title: Tax Credits for Provision of Free Medical Care. AP-PROVED.

RESOLVED: That MSMS seek legislation which would allow physicians to receive tax credits for the provision of free medical care at both the state and federal taxing authority levels.

RESOLUTION 88-97A

Allen F. Turcke, MD, for the Genesee County Delegation Title: Congratulations to the Genesee County Medical Society Members Donating Their Time to the Greater Flint Area Health Coalition. ADOPTED AS AMENDED.



RESOLVED: That MSMS write a letter of commendation to the Genesee County Medical Society (GCMS) in recognition of the members who are involved in the Greater Flint Area Health Coalition activities; and be it further

RESOLVED: That MSMS encourage other physicians to be involved in similar efforts in their own communities.

RESOLUTION 89-97A

Allen F. Turcke, MD, for the Genesee County Delegation Title: Support Standard Enforcement of Safety Belt and Child Restraint. ADOPTED AS AMENDED.

RESOLVED: That MSMS pursue legislation to support the passage of House Bill 4280 or its equivalent during this session of the legislature to cover standard enforcement of seat belt and child restraint usage.

RESOLUTION 90-97A

Allen F. Turcke, MD, for the Genesee County Delegation Title: Physician Question and Counsel Patients Regarding Tobacco Usage. ADOPTED AS AMENDED.

RESOLVED: That MSMS join with county medical societies in asking all physicians of all specialties to identify smokers and encourage them to quit; and be it further

RESOLVED: That MSMS join with county medical societies to ask all physicians to document nicotine status in the patients record.

RESOLUTION 91-97A

Allen F. Turcke, MD, for the Genesee County Delegation Title: Fine Tuning of House Bill 4529 or 1994, A Revision of PA 100 of 1994, NO ACTION.

RESOLUTION 92-97A

Allen F. Turcke, MD, for the Genesee County Delegation Title: Endorse Environmental Protection Agency (EPA) Air Quality Standards. REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS endorse the Environmental Protection Agency (EPA) proposals for stricter air quality standards for ozone and particulates.

RESOLUTION 93-97A

Mary E. Rother, MD, Michigan Academy of Family Physicians, for Archie W. Bedell, MD

Title: International Medical Graduate Dilemma. NO AC-TION.

RESOLUTION 94-97A

Joseph E. Kincaid, MD, Kalamazoo County Title: Appropriate End of Life Therapy. ADOPTED AS AMENDED.

RESOLVED: That MSMS continue to work at all levels for im-

proved pain management and symptom control; and be it further

RESOLVED: That MSMS continue education on recognition of depression and its adequate therapy; and be it further

RESOLVED: That MSMS continue to promote advance directives: and be it further

RESOLVED: That MSMS continue support for hospice including education about hospice and the use of hospice care.

RESOLUTION 95-97A

Domenic R. Federico, MD, Kent County Title: AMA as Patients Advocate: Mammography Screening Recommendation. ADOPTED AS AMENDED.

RESOLVED: That MSMS openly and vigorously endorse the following schedule for mammographic screening: baseline mammorgraphy prior to age 40 and subsequent annual mammograms beginning at age 40. If there are risk factors present initiation of screening should be considered sooner than age 40; and be it further

RESOLVED: That the Michigan Delegation to the AMA seek AMA endorsement of these mammography screening recommendations.

RESOLUTION 96-97A

Domenic R. Federico, MD, Kent County Title: Parity With Prescription Drug Coverage. AP-PROVED.

RESOLVED: That the Michigan Delegation to the AMA request the AMA to support legislation to mandate coverage for prescription contraceptives for all insurance and self insured plans that provide prescription drug coverage.

RESOLUTION 97-97A

Domenic R. Federico, MD, Kent County Title: AMA as Patient Advocate: PAP Smear Screening. RE-FERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS adopt a policy supporting routine annual PAP smears starting at age 18 or the age at which sexual activity has begun, whichever is less; and be it further

RESOLVED: That the Michigan Delegation to the AMA request the AMA to adopt a policy supporting routine annual PAP smears starting at age 18 or the age at which sexual activity has begun, whichever is less.

RESOLUTION 98-97A

Irving Miller, MD, MI Chapter, American Academy of Pediat-

Title: Human Relations Programs for Children. ADOPTED AS AMENDED.

RESOLVED: That MSMS support the concept of comprehensive human relations skills development in schools for grades K through 12 with implementation to be left to local school districts.

RESOLUTION 99-97A

David R. Johnson, MD, Chief Medical Officer, Michigan Department of Community Health

Title: Lead Screening of Young Children. APPROVED.

RESOLVED: That MSMS urge all its members to screen children for their risk of contact with lead hazards and subsequent lead poisoning, and to complete a capillary or venous blood test for any child deemed to be at high risk for this serious health problem.

RESOLUTION 100-97A

David R. Johnson, MD, Chief Medical Officer, Michigan Department of Community Health

Title: Risk Reduction for Sudden Infant Death. AP-PROVED.

RESOLVED: That MSMS urge its members to educate parents of young infants and parents-to-be of the benefits of putting young infants to sleep on their backs, refraining from smoking around young infants and pregnant women, and avoiding all soft, cushiony materials in the cribs of young infants.

RESOLUTION 101-97A

David R. Johnson, MD, Chief Medical Officer, Michigan Department of Community Health

Title: Alcohol, Tobacco and Other Drugs (ATOD) Screening of Pregnant Women by Primary Physicians. ADOPTED AS AMENDED.

RESOLVED That MSMS encourage its members to conduct alcohol, tobacco and other drugs (ATOD) assessments of pregnant women by primary physicians as health initiative for Michigan's future.

RESOLUTION 102-97A

James P. Gallagher, MD, Wayne County for Hassan Amirikia, MD Title: Auto Insurance Premium - Medicaid Reimbursement. DISAPPROVED.

RESOLUTION 103-97A

David K. Johnson, MD, for Anna H. Broecker, MD, Omero S. Iung, MD, the Womens Physicians and Executive Committees of the Ingham County Medical Society

Title: Permanent Retention of Part Time Dues Category. ADOPTED ON FIRST READING.

RESOLVED: That MSMS retain the part time dues category permanently and that the Constitution and Bylaws be properly revised to reflect this category; and be it further

RESOLVED: That the definition for part time members as proposed in the original resolution 3-94A, be adopted:

"Part Time Members: Shall be those physicians who work more than four hours but less than twenty hours per week on an average over a year's time. They shall pay one-half annual active membership dues, and shall be eligible for all active membership benefits including the right to vote, hold office, and be eligible for committee positions."

RESOLUTION 104-97A

Stephen E. Fisher, MD, Muskegon County, for John A. Mulder, MD

Title: Physician Assisted Suicide. NOT ADOPTED.

RESOLUTION 105-97A

Robert L. Bree, MD, Washtenaw County

Title: Payment of Medicare Deductible and Coinsurance Amount, APPROVED.

RESOLVED: That MSMS seek legislation that requires any insurer, health maintenance organization, third party administrator and network manager in the State of Michigan to pay the coinsurance and deductible amounts up to the Medicare fee schedule.

RESOLUTION 106-97A

David K. Johnson, MD, Ingham County, for Gregory G. Messenger, MD

Title: MSMS Opposes Secret Files and Unofficial Investigations by the Bureau of Occupational and Professional Regulations, Office of Health Services. APPROVED.

RESOLVED: That MSMS no longer tolerate and seek legislation to stop and prevent the unauthorized investigation of physicians and the unauthorized development of files against physicians by the administration of Bureau of Occupational and Professional Regulations (BOPR), Office of Health Services: and be it further

RESOLVED: That MSMS ask the Bureau of Occupational and Professional Regulations (BOPR), Office of Health Services to have all allegations against physicians reviewed by licensed physicians, and any licensee named in any allegation be immediately notified of the allegation, including the subject matter and person or government agency making the allegation; and be it further

RESOLVED: That MSMS ask the Bureau of Occupational and Professional Regulations (BOPR), Office of Health Services to have all unsubstantiated allegations removed from the file immediately.

RESOLUTION 107-97A

Mitchell A. Rinek, MD, Ingham County, for Elizabeth Hutchinson, MD

Title: Condemning Penalties for Physicians' Proper Prescription Performance. NOT ACCEPTED AS A LATE RESO-LUTION.

Delegates elect colleagues to MSMS, AMA posts

The 1997 House of Delegates elected the following MSMS officers and directors, as well as delegates and alternates to the American Medical Association.

Officers (to the 1998 House of Delegates)

	in the contract of a contract of
President	Peter A. Duhamel, MD, Oakland
President-elect	Cathy O. Blight, MD, Genesee
Secretary	Thomas R. Berglund, MD, Kalamazoo
Assistant Secretary	Thomas C. Payne, MD, Ingham
Treasurer	Billy Ben Baumann, MD, Oakland
Assistant Treasurer	D. Moore Hislop, MD, St. Clair
Speaker	Dorothy M. Kahkonen, MD, Wayne
	Paul O. Farr, MD, Kent

District Directors (to the 1998 House of Delegates)

1st District	James P. Gallagher, MD, Wayne
2 nd District	Mitchell A. Rinek, MD, Ingham
3 rd District	Jeffrey M. Jones, MD, Calhoun
4 th District	James B. Kilway, MD, Kalamazoo
5 th District	M. Gary Robertson, MD, Kent
6 th District	AppaRao Mukkamala, MD, Genesee
9th District	K. H. Musson, MD, Grand Traverse
11th District	Robert C. Packer, MD, Muskegon
13th District	Rudy W. Stefancik, MD, Houghton
15th District	John H. McLaughlin, MD, Oakland
	Alan M. Mindlin, MD, Oakland
	Donald B. Muenk, MD, Macomb



Flint pathologist Cathy O. Blight, MD, was named MSMS presidentelect. She will be the second woman physician to serve in the top MSMS bost.

Delegates to the AMA (to the 1999 House of Delegates)

Susan Hershberg Adelman, MD, Wayne Peter A. Duhamel, MD, Oakland Thomas C. Payne, MD, Ingham Rhoda M. Powsner, MD, Washtenaw Krishna K. Sawhney, MD, Wayne B. David Wilson, MD, Kalamazoo Marguerite R. Shearer, MD, Washtenaw (1998 - to complete one year of an unexpired two year term)

Alternate Delegates to the American Medical Association (to the 1999 House of Delegates in order of seniority)

Willard S. Stawski, MD, Kent Carl F. Hammerstrom, MD, Marquette AppaRao Mukkamala, MD, Genesee Alan M. Mindlin, MD, Oakland Cecil R. Jonas, MD, Wayne Hassan Amirikia, MD, Wayne Tama D. Abel, MD, Washtenaw

ELECTION RESULTS



The three active, current MSMS presidents-President Peter A. Duhamel, MD; President-elect Cathy O. Blight, MD, and Immediate Past President W. Peter McCabe, MD, join forces for an official portrait.





Past presidents of MSMS gathered at the House of Delegates. From left, top row, they are Thomas C. Payne, MD; Carl A. Gagliardi, MD; Richard D. McMurray, MD; B. David Wilson, MD; Gilbert B. Bluhm, MD; Robert D. Burton, MD; Robert E. Paxton, MD, and Donald K. Crandall, MD. From left, front row, are W. Peter McCabe, MD; Susan H. Adelman, MD; Thomas R. Berglund, MD; and Louis R. Zako, MD. At right is Fred W. Bryant, MD.

RESOLUTION 108-97A

Harvey W. Halberstadt, MD, Oakland County Title: Board Certification. DISAPPROVED.

RESOLUTION 109-97A

Harvey W. Halberstadt, MD, Oakland County for the MI Psy-

Title: Change Health Care Financing Administration Rules to Include Psychiatric Outpatient Programs Within the Family Medicine Exemption. NO ACTION.

RESOLUTION 110-97A

Robert S. Levine, MD, for the Oakland County Delegation Title: Medication Information. APPROVED

RESOLVED: That MSMS applaud the efforts of pharmacies to educate patients and prevent medication induced problems; and be it further

RESOLVED: That MSMS strongly express our concerns about inappropriate guidance given to our patients by pharmacists who do not take the time to obtain an adequate drug history so they can ascertain if our patient is at significant risk for medication related side effects and/or problems caused by the interactions of various medications; and be it further

RESOLVED: That MSMS work with the pharmacist and pharmacy organizations within Michigan to develop guidelines and procedures to prevent our patients from getting misinformation and/or inappropriate guidance from the pharmacist or pharmacy dispensing a prescribed agent to our patients.

RESOLUTION 111-97A

Robert S. Levine, MD, for the Oakland County Delegation Title: Automobile Safety Recalls. APPROVED.

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek modification of the National Traffic and Motor Vehicle Safety Act requiring at the time of title transfer certification as to the status of repairs and/or modification required as a result of a safety recall; and be it further

RESOLVED: That MSMS seek legislation that would prohibit any vehicle with an uncorrected safety defect to be offered for rent or lease within the State of Michigan; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek modification of the National Traffic and Motor Vehicle Safety Act that would prohibit any vehicle with an uncorrected safety defect to be offered for rent or lease; and be it further

RESOLVED: That the Michigan Delegation to the AMA ask the AMA to seek modification of the National Traffic and Motor Vehicle Safety Act requiring manufacturers to notify the appropriate state motor vehicle license bureau of each and



every vehicle with a known safety defect and prohibit the title transfer of any vehicle with an unresolved safety defect.

RESOLUTION 112-97A

Jaime V. Aragones, MD, for the Oakland County Delegation Title: Renewal of Drivers Licenses by Mail. REFERRED TO THE BOARD FOR STUDY AND ACTION.

RESOLVED: That MSMS express its concerns regarding the mail order renewal of driver's licenses in patients with progressive eye diseases and seek regulation or legislation requiring that all individuals with progressive eye disease undergo eye examination at least annually; and be it further

RESOLVED: That all individuals with progressive eye diseases undergo periodic ophthalmologic testing to determine whether they meet the standards for safe driving in the State of Michigan as stipulated by the Michigan Vision Specialist Statement.

RESOLUTION 113-97A

Joseph A. Arena, MD, for the Oakland County Delegation Title: Fee Splitting. NO ACTION.

RESOLUTION 114-97A

Peter T. Muller, MD, for the Oakland County Delegation Title: Assignment of Student Delegates and Alternate Delegates. REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That students continue to be recruited and encouraged to participate in the governance of organized medicine, and that students participate in the House of Delegates as "at large" delegates rather than representative of an individual county medical society.

RESOLUTION 115-97A

Gertraud Wollschlaeger, MD, for the Oakland County Delegation Title: Noise Levels in Public Places. NO ACTION.

RESOLUTION 116-97A

Peter S. Chang, MD, for the Young Physicians Section Title: Insurance Company Payment Denials. REFERRED TO THE BOARD FOR STUDY.

RESOLVED: That MSMS request information from the membership regarding this current insurance practice and assess the practice of insurance companies sending out refusals prospectively and retrospectively for each of the specialties where this practice has occurred; and be it further

RESOLVED: That MSMS collect information on prospective and retrospective denials, publish this data for patients to use when considering their insurance options; and be it further

RESOLVED: That MSMS denounce the practice of prospective and in some cases retrospective denials as detrimental to patients and be seen as an obstruction of their receiving necessary medical care.

RESOLUTION 117-97A

Rudy W. Stefancik, MD, Houghton County
Title: MSMS House of Delegates Representation.
ADOPTED.

RESOLVED: That the House of Delegates amend the MSMS Bylaws in the following fashion:

- 1) Add the following sentence to Bylaw 12.10: The president of a component medical society that all or part of which is located more than 400 miles by road from the site of the House of Delegates may designate a district director of its district to serve as a delegate to the House of Delegates, provided that the Reference Committee on Credentials and Tellers certifies that no other member of that component society is in attendance at that meeting and is available to represent that component society. In the case of such designation of a single district director by two or more component societies, said district director shall have only one vote on all matters before the House of Delegates.
- 2) Substitute the following as the first sentence of Bylaw 12:20 after the title: Except as provided in Bylaw 12:10, the officers of this Society and the members of the Board of Directors shall be ex-officio members of the House of Delegates, but with the exception of the Speaker and Vice Speaker of the House of Delegates, shall be without power to vote therein.

RESOLUTION 118-97A

Title: Family Planning: Comprehensive School Health Program. NOT ACCEPTED AS A LATE RESOLUTION.

Peter A. Duhamel, MD

132nd MSMS president asks doctors to contribute to communities

66 ervice is the rent we pay for the privilege of living." That quote is from Stephen Covey, author of the hugely popular book, The Seven Habits of Highly Effective People. He also states, "more important than being successful is being significant." Significance means making a contribution to others. Significance means making a difference.

Service is something we all do every day. The concept of rendering service was instilled into our souls from our first days in medical school, possibly even sooner, when we first became

aware of our noble profession and chose it as our particular vocation.

We were inspired by the friendly family doctor of our childhood, or chose an admired relative as a role model, or were just turned on by the good we could do for humanity.

Our souls are enriched through the service we provide every day of our working lives. We serve each and every patient in many ways that can never be reimbursed. We speak with them, listen to all their troubles and problems, more than just their medical complaints. Sometimes we may accom-

plish more good for them just by listening with our hearts.

But there's another kind of service I want to talk with you about today. It is the service which I am making the theme of my presidency. It is something much more than what I've already described.

I'm talking about going beyond your professional service and committing to community service service to the community in which we live and earn a living, the community where our kids go to school, where we go shopping, where we attend church. And most important of all, where our patients live.

Community involvement... why should we, why must we be

involved? We doctors are by tradition highly respected in our communities. We must do something to continue to earn that respect.

We earn good livings in our communities,

and we owe it to our communities to give something back in the form of community service. We physicians must begin taking more responsibility for the leadership so many of our communities so desperately need.

Believe it or not, people do listen to us, and not only about medical matters. You'd be surprised how many people know who we are, and acknowledge that we do have more than a minimal education. We must show them that we are interested in what's going on in the world around us.

Community service can take many forms, depending

on one's talents and inclinations.

Your church or synagogue might be a good place to start. How about school activities? It's easy to get involved in the PTA. I can remember when a local physician was always a member of the school board, even board president. In fact, in recent years, two school boards in



"Doctors and their Families Make a Difference" is the theme of incoming President Peter A. Duhamel, MD's term.

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W. Peter McCabe, MD

Assisted suicide debate compels doctors to explore ethical issues

In looking back on my year as MSMS president, I'm reminded of the biblical imperative that one I renders unto Caesar the things that are Caesar's, and to God the things that are God's.

First to Caesar. A considerable amount of Society time and effort has been expended this past year on setting up a management services organization. If we physicians are to secure a place at the table as the health care landscape

Doctor McCabe places the MSMS presidential medal around Doctor Duhamel's neck.

is carved up, we must support and nurture enterprises such as this.

You'll be hearing a lot more about this as time, particularly the next 90 days, goes by. As they say on late night TV, operators are standing by to take your order.

So much for Mammon. On a more celestial plan we at MSMS have continued to explore ethical boundaries of medical practice.

This State, and this Society in particular, continues at the forefront of the debate on assisted suicide through no particular fault of our own but rather because of a grizzled little pathologist down in Royal Oak who's been pushing the envelope. And, I must admit, with some justifica-

tion.

Because for years we in medicine have been hell bent on a therapeutic arms race that all too often lacks a counterbalancing pause to reflect on the human toll this sometimes extracts

from our patients.

If there's any redeeming value to the eerie burlesque acted out in Volkswagen vans in the back alleys and deserted rest stops of Oakland County, it's that it's forced us to take that pause for reflection.

Tomorrow this House will consider a number of resolutions which seek to change a policy on assisted suicide which it adopted in 1993.

Central to this policy is a conviction that end of life decisions should not be legislated or regulated, but instead should be left to the privacy of the doctor/patient relationship.

It has also been felt that, if assisted suicide were ever to be considered, it should be done only after all other options for comfort care had been exhausted, and only under sharply limited circumstances.

This policy has served MSMS well over the intervening years. Yet there has been unfinished business. Left undefined are just what the limited circumstances are.

In an attempt to see whether they could be codified, I convened a number of forums of interested parties representing all shades of the philosophical spectrum, anchored by physician members of our Medical Society.

Their charge was to see if parameters . . . guidelines if you will . . . could be constructed.

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Michigan have been chaired by MSMS Alliance members.

And then there are the many service clubs in every community. They are very receptive to having physicians as members. Many of their charity projects have medical significance, such as the leader dogs for the Lions Clubs, and stamp out polio for the Rotary.

Another important volunteer community activity can be with your local chamber of commerce. After all, each and every one of us is a local business person, same as the druggist, the jeweler, the retailer and the filling station on the corner.

And we need to have an attractive business community or people won't come to our location. You'd be surprised at how much we have in common with the members of the business community and they are certainly interested in our opinions.

Our expertise in health care may help guide the chamber in selecting certain group health plans to offer its members. We also can advise concerning public health issues, safety in the workplace, or immunization programs.

And finally, an aspect of community service near and dear to my heart is involvement in the grass roots political scene. You've all probably heard me preach this many times before, but I'm going to say it again. Your state medical society has had many major accomplishments in the Michigan state legislature the past few years: two sweeping tort reform bills; the Michigan Patient Bill of Rights; significant victories in public health issues; defeat of scope of practice bills that threaten the health of our patients. Much of this success is due to your hard working MSMS staff and lobbyists. But this success really comes from physicians who have taken the time from their busy practices to testify, lobby, telephone and personally contact key legislators.

The very best way to make an initial contact with a legislator is in your community. Call up your legislator and invite him or her to come

have lunch in the doctors' dining room at your hospital. Believe me, they'll be there! They can't resist meeting a group of doctors, and it gives your colleagues a chance to tell the lawmakers what's on their minds.

At election time, you can host a fund raiser or volunteer to be more active in the campaign organization.

Believe me, if you have been instrumental in helping a candidate win his or her very first election, you will be a friend for life. You will always have access to that legislator to ask him or her to support the medical society's position on any bill under consideration.

And you should be aware of the community service awards recently established by the Michigan State Medical Society.

Nothing has pleased me more in the past two years than attending county medical society meetings to present these community service awards. Meeting these outstanding individuals and listening to them tell what it is that motivates them has given me an overwhelming sense of pride in our chosen profession. I hope that all of us can learn from their example and go back to our homes, get involved in community service, and we truly will make a difference.

This fall, MSMS will be participating in the national Make-a-Difference Day which you will be hearing and reading about in the next several months.

Tomorrow when you return to your homes, I ask you to look around as you drive into town, as you drive through your neighborhoods to observe your community. Scan your local newspapers. Talk with your community leaders. Find out what needs to be done, then help organize your community to see that it gets done. See how you can make a difference.

I invite each one of you now to kick-start yourself into a lifelong pattern of community service. I challenge you to prove that doctors can and do make a difference in their communities!

continued from page 33

And if they couldn't, at least see if boundaries could be defined beyond which all agree there should be no trespass.

I had hoped their dialogue would be completed for acceptance or rejection by this House, but their work has proven more difficult than anticipated and only an interim report is available.

Their tortuous deliberations reflect how difficult the issue is. And no matter what our collective and individual views on the subject may be, society at large is, at the least, evenly divided on the subject.

And, frankly, so is our profession if one is to believe the findings of the Institute for Social Research at the University of Michigan.

At tomorrow's awards ceremony I will be presenting Presidential Citations to a number of people who have made significant contributions to the profession.

For a brief, fleeting moment, until I regained my senses, I had seriously considered giving one to Dr. Jack Kevorkian, in the same spirit that Time Magazine's Person of the Year isn't always the nicest guy, but rather a person who's had a significant impact on the news, i.e., Ayatollah Khomeni.

And there's no doubt that Kevorkian has driven the issue. I question whether any of us, particularly the AMA would be addressing endof-life issues to the extent we have if he hadn't started his bizarre crusade.

After all, our track record hasn't been all that great, whether it's been underrating terminal pain, ignoring do-not-resuscitate directives, or embracing the hospice movement with something less than enthusiasm.

It's just unfortunate that it's taken a Jack Kevorkian to focus our attention.



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Michigan State Medical Society Mackinac Island

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"MMA provides an opportunity for we physicians to "buy-in' to an organization that will help us shape our practice environment into the future." Cathy O. Blight, MD, Flint



"I invested in MMA because it's a very tangible step I can take to empower Michigan physicians in these trying times. I believe that MMA will give us back some of our power." Billy Ben Baumann, MD, Pontiac



"MMA provides physicians in Michigan the ability to sculpt their practice environment for the future. It's a way for physicians to be proactive and to be able to evolve our marketplace." Robert J. Jackson, MD, Allen Park



"Physician empowerment and autonomy are vital to the survival and prosperity of the profession and to protecting patients' interests. MMA, in my view, is a critical factor in preserving that autonomy and creating that

empowerment. A physician-owned and physician-minded organization like MMA provides me a level of trust I simply do not have with physician practice management companies and hospital systems." Louis R. Zako, MD, Harbor Springs



"Certain projects of critical importance to patient care may only be accomplished by an association of physicians rather than by individuals. Working together, we will accomplish far more than working alone."

John A. Rupke, MD, Grand Rapids

Invest in Michigan Medical Advantage and in the continuing independence of the medical profession

Why should physicians take stock in MMA?

"MMA is a physician-owned, physician minded company with the interests of physicians and their patients at heart," said MMA chair Krishna K. Sawhney, MD. "Now is the time for physicians to step up and make an investment in their professional future."

As you consider investing this month in MMA, consider the following:

Question: What business is MMA doing now?

Answer: Michigan Medical Advantage has agreements with five physician organizations (POs) throughout the state for services ranging from strategic planning and development to full administrative management. MMA also is currently involved in various stages of contract review and negotiation—on behalf of the physicians—with four HMOs. These contracts include commercial, Medicaid and point-of-service plans. Additionally, MMA has issued contract proposals to three other POs for a variety of services.

Question: Does MMA manage physicians' practices?

Answer: MMA will not manage physicians' practices. MMA is a contract management MSO. MMA will assist POs and PHOs in negotiating managed care contracts and then will provide the utilization management, quality management, credentialing, capitation stop-loss and other services to help physicians deliver high quality, cost-effective care under those contracts.

Question: How will I make money by investing in MMA?

Answer: MMA investors may make money through dividends declared by the company or through capital appreciation. The most powerful reason for investing in Michigan Medical Advantage, however, is to help establish a management services organization that is physicianowned and physician-minded. It is an investment in the medical profession and in your professional future. Maybe not today or tomorrow or even next year, but eventually, all physicians in Michigan will need the services of Michigan Medical Advantage. If it's not created today, it will not be available tomorrow.

Stock offering runs through July 29, so act now!



Michigan Medical Advantage is the new physician-owned, physician-minded company created to help Michigan physicians succeed in a managed care environment.

What if an MSO were owned by the same people it was intended to help?

Details of Michigan Medical Advantage Stock Sale

Who May Participate:

Michigan residents who are licensed physicians or officers, directors or managers of MMA, MSMS, the Michigan Physicians Mutual Liability Company, county medical societies, physician organizations or medical groups.

What's Being Offered:

- Up to 350,000 shares of Class A Common Stock at \$10 per share.
- This stock represents a Michigan registered security.
- The company has a single investor class (all voting shares) with the same valuation as the original investors (MSMS and MPMLC).
- The minimum purchase is 250 shares \$2,500. The maximum purchase is 1,500 shares \$15,000.

Where to Call to Purchase Stock

The prospectus is available through McDonald and Company Securities, Inc. Their offices are located in:

You have until July 29, 1997 to purchase this stock.

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Contact Person 800-377-2788 Ann Arbor John Fischer, MD **Battle Creek** Charles McCann 800-966-4510 Birmingham Jonathan Uffelman 800-553-2056 East Lansing William Eastin 800-448-5747 **Grand Rapids** Richard Leist 800-548-6011 Robert Hamilton 800-417-2650 Grosse Pte. Woods Holland Bruce Johnson 800-331-6961

To learn more about MMA, please call 517-336-1400.

Business side of your practice need attention?

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- Hospital Financial Information in Brief
- MSMS/MPMLC Risk Management Programs
- Physician Service Group Endorsed Products and Services
- Michigan Medical Advantage management services organization

For assistance, call MSMS at 517-337-1351 or send e-mail to msms@msms.org. Find us online at http://www.msms.org.



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MSMS honors many physicians

National Presidents Awards

Awards were presented to the following for their service as presidents of national medical organizations: Charles J. Krause, MD, President, American Academy of Otolaryngology, Head and Neck Surgery Paul R. Lichter, MD. President, American Academy of Ophthal-

Raymond R. Margherio, MD, President.

The Retina Society George A. Williams, MD, President, The Vitreous Society

Presidential Citations

mology

This award, presented to physicians or lay persons who have made an outstanding contribution to medicine in the state, was presented to: Busharat Ahmad, MD, Monroe H. Harvey Gass, MD. Bingham Farms Eunice Ott, Retiring Executive Director of Berrien County Medical Society

Frederick and Besse Moulton Plessner Award

This award is presented by the MSMS Board of Directors to a rural physician who "best exemplifies the practice of a rural country practitioner." This years recipient was: Charles R. Zimont, MD, Constantine



In the waning hours of his MSMS presidency, W. Peter McCabe, MD. had the great privilege of awarding the society's highest honor, the Presidential Citation. Busharat Ahmad, MD. Monroe, right, was one of the three recipients, honored for his state and national-level championing of International Medical Graduates' issues.



Accepting a Presidential Citation from Doctor McCabe on behalf of retiring Berrien County Medical Society Executive Eunice Ott. was, right, Fred Busse, MD. Niles.



Harvey Gass, MD, Detroit, left, received a Presidential Citation from Doctor McCabe for his contributions in representing physicians with Blue Cross Blue Shield of Michigan.



Charles R. Zimont, MD, Constantine, left, received this year's Plessner Award for best exemplifying the character of the rural family physician. Presenting the award was MSMS Board Chair Krishna K. Sawhney, MD.



Receiving a National President's Award from MSMS President W. Peter McCabe, MD, right, was Raymond R. Margherio, MD, President, The Retina Society.

50 Year Awards

Emil J. Alban, MD, Dearborn Joseph A. Arena, MD, Madison Heights Constantine T. Aries, MD, Dearborn Heights Shirley Austin, MD, Detroit Margaret A. Baima, MD, Farmington Thomas M. Batchelor, MD, West Palm Beach, FL James E. Beard, MD, Dearborn Edwin L. Berger, MD, Farmington Hills Isak O. Berker, MD, Lapeer Chester J. Bogucki, MD, Port St. Lucie, FL David W. Bostian, MD, Ann Arbor Michael J. Brennan, MD, Grosse Pte. Shores Bruce L. Brown, MD, Kalamazoo Frederick J. Cady, MD, Saginaw Nora F. Chang, MD, Cadillac Graham F. Colquhoun, MD, Battle Creek Victor Curatolo, MD, Harrison Twp. Gerald G. Durak, MD, Bloomfield Donald E. Economy, MD, Dearborn Robert N. Elliott, MD, Birmingham Gomer P. Evans, MD, Detroit

Steven J. Figiel, MD, Dearborn Gerald C. Fine, MD, Grosse Pte. Park William J. A. Ford, MD, Owosso Gordon R. Forrer, MD, Saginaw Edward M. Fugate, MD, Muskegon Louis B. Gariepy, MD, Southfield Irfan S. Gervin, MD, Alma William S. Gladstone, MD, Kalamazoo James R. Glessner, MD, Grand Rapids James A. Gunn, MD, Grand Rapids Louis F. Hayes, MD, Murrells Inlet, SC Hugh W. Henderson, MD, Roseville Miroslaw W. Hnatiuk, MD, Livonia William J. Hornbeck, MD, Muskegon Heights Rudolph M. Jarvi, MD, Saginaw J. Frederic Johnson, MD, Birmingham William J. Jones, MD, Salem, SC Jean P. Karr, MD, Jackson Mualla Kaynak, MD, Fairfield, CT Ingram J. Kleaveland, MD, Muskegon Edward J. Klopp, MD, Brevard, NC William L. Knapp, MD, Ann Arbor



Medical school graduates of the 1947 class gathered at the House of Delegates to receive 50-year pins.

David A. Krevsky, MD, Allen Park Morton J. Kripke, MD, Washington Patrick M. Littlejohn, MD, Kalamazoo Rosser L. Mainwaring, MD, Dearborn Joseph D. Mann, MD, Grand Rapids Vincent J. Marecki, MD, Dearborn Harry G. Mauthe, MD, Bradenton, FL John E. McEnroe, MD, Petoskey Harry B. McGee, MD, Bay City Edward Missavage, MD, Birmingham John W. Moynihan, MD, Dearborn Atalay M. Murguz, MD, Troy Eugene J. Nalepa, MD, Clarkston John M. Nehra, MD, Grosse Pte. Shores Alvin N. Norris, MD, Sarasota, FL Robert S. Ormond, MD, Holly John J. O'Toole, MD, Benton Harbor Perry E. Prather, MD, Traverse City Michael Raftery, MD, Port Huron William U. Reidt, MD, Roseville Bernard J. Reizner, MD, Jackson Edward E. Reynolds, MD, East Lansing Lewis D. Rickman, MD, Mt. Clemens Charles S. Rogers, MD, Venice, FL Walter S. Rothwell, MD, Trenton Daniel L. Rousseau, MD, Mt. Clemens Richard R. Royer, MD, Detroit

Carolyn S. Salisbury, MD, Sun City, AZ Jose M. Siero, MD, Hazel Park Robert O. Smith, MD, Fort Pierce, FL Joseph C. Steffey, MD, Traverse City Paul R. Stimson, MD, Lansing G. Edward Stokes, MD, Traverse City Charles H. Stone, MD, Lincolnville, ME Raymond O. Swann, MD, San Antonio, TX Alfred B. Swanson, MD, Grand Rapdis Bernard J. Sweeney, MD, Traverse City James H. Tisdel, MD, Tucson, AZ Arthur A. Ulmer, MD, Grosse Pte. Shores William T. Unkefer, MD, Traverse City William L. Van Arsdale, MD, Athens Ellis J. Van Slyck, MD, Grosse Pte. Shores Andrew H. Veldhuis, MD, Mt. Pleasant Joy Y. Wang, MD, Livonia John F. Weiksnar, MD, Grosse Pte. Edwin J. Westfall, MD, West Bloomfield Arno A. Whipple, MD, Moorestown John L. Wiese, MD, Grand Rapids Daniel C. Wilkerson, MD, Springport John M. Wood, MD, Northport Thomas B. Wright, MD, Bay City Charles M. Wylie, MD, Ann Arbor Irving I. Young, MD, Orchard Lake

MSMS names life, retired members

SPECIAL MEMBERSHIPS - 1997

Thomas R. Berglund, MD, Secretary

LIFE MEMBERS - Members who have maintained an active membership in good standing for twenty-five years in any one or more constituent state societies of the American Medical Association, with any five years in Michigan, with dues baid for the previous calendar year and who (1) have attained the age of 70 years or, (2) have been in practice for 50 years.

BAY

Martin D. Jaffe, MD George E. Loan, MD

GENESEE

Carlton K. Dettman, MD Richard A. Dykewicz, MD

JACKSON

Mary E. Bentley, MD

KALAMAZOO

Charles O. Peake, MD

KENT

Youn S. Kim, MD

Jerome F. Mancewicz, MD

LAPEER

Merle B. Haney, MD

MACOMB

Harold P. Charbeneau, MD

Harvey A. Krieger, MD

Vincent R. O'Shee, MD

Mahmoud M. Selim, MD

Raymond D. Sphire, MD

MONROE

John J. Burroughs, MD

OAKLAND

Reuven Bar-Levay, MD

Glenn B. Carpenter, MD

Dale R. Drew, Md

James W. Gell, MD

Channing T. Lipson, MD

Mehmet N. Ozdagler, MD

Robert Pool, MD

Joseph L. Schirle, MD

Yehya Shawky, MD

Cevdet Turan, MD

Freeman M. Wilner, MD

SAGINAW

William G. Mason, MD

ST. CLAIR

John A. Youngs, MD

ST. JOSEPH

John D. Smith, MD

WASHTENAW

Lyle M. Allis, MD

E. Esquejo Capili, MD

Parvis Meghnot, MD

Herbert Schunk, MD

Frederik S. VanReesema, MD

Pieter D. Vreede, MD

WAYNE

John M. Battle, MD

Robert G. Borchak, MD

Donald R. Brock, MD

Arthur M. Clark, MD

Luis Fanego, MD

Angel Farina, MD

Zdzislaw Fiutowski, MD

Raymond S. Henkin, MD

Michael Iacobellis, MD

Robert S. Jampel, MD

Sidney B. Jenkins, MD

Martin W. Kleiman, MD

Stanley H. Levy, MD

Jack A. Litwin, MD

James E. Remski, MD

Graciela R. Rojas, MD Alexander N. Rota, MD

E.N. Rottenberg, MD

Klaus P. Schmidt, MD

Werner U. Spitz, MD

Glafkos H. Theodoulou, MD

V.K. Vaitkevicius, MD

Fred S. Whitehouse, MD

RETIRED MEMBERSHIPS - Members who have maintained active membership in any one or more constituents state societies in Michigan for a period of five or more years, and who have retired from practice.

BARRY

Larry L. Blair, MD

BERRIEN

Herbert A. Atkinson, MD

William G. Schetter, MD

Robert S. Schindler, MD

CALHOUN

George M. Chamberlin, MD

Chihsing C. Chen, MD

Joseph R. Jaconette, MD

Melvin H. Johnson, MD

Charles L. Seifert, MD

DELTA

Teresita Go, MD

GENESEE

R. Roderic Abbott, MD

Peter R. Bover MD

Robert L. Cross, MD

Robert E. James, MD

David W. Lee, MD

John A. Lusk, MD

Conrad Reinhard, MD

Fidel B. Seneris, MD

James D. VanBrocklin, MD

GRAND TRAVERSE-LEELANAU-

BENZIE

William H. Cartwright, MD

James P. Jacobs, MD

Lawrence S. Loesel, MD

Gene D. Tang, MD

Richard J. Walterson, MD

HILLSDALE

Barrie Dunseath, MD

HOUGHTON-BARAGA-

KEWEENAW

Robert B. Neale, MD

HURON

John R. Clara, MD

INGHAM

Rolland E. Bethards, MD

Byong-Du Choi, MD

Raymond C. Kinzel, MD

Paul C. Linnell, MD

H.C. Tien, MD

IOSCO-ARENAC

Hans H. Fischer, MD

James E. Jacques, MD ISABELLA-CLARE

SPECIAL MEMBERSHIPS

Ray W. Chamberlin, MD Ara A. Sheperdigian, MD Leo R. Wickert, MD

JACKSON

Nicholas G. Bennett, MD Parviz Samii, MD Pouran S. Samii, MD John F. Stageman, MD Richard M. VanSchoick, MD

KALAMAZOO

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Action Reports of the Board of Directors

Krishna K. Sawhney, MD

MSMS is a vital organization, and a leader among state medical societies, particularly because we are growing in membership. That growth comes because we are meeting the needs of our members. How are we doing that?

• Creation of Michigan Medical Advantage • Passage of the Michigan Patient Bill of Rights • Holding back expansion of scope of practice • Fighting for quality in the Medicaid capitation plan • Raising immunization rates in Michigan infants • Health data collection • Presentation of physician education programs • Self-analysis of our structure and election process • Creation of the AMA International Medical Graduate Section • Membership, at an alltime high near 13,000.

Following are details about selected actions of your Board of Directors in 1996-97.

ACTION REPORT #1 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 3-96A, "MSMS to Join the National Association of Physicians for the Environment"

RECOMMENDATION: That MSMS not join the National Association of Physicians for the Environment, and that this report be adopted in lieu of Resolution 3-96A.

HOD Resolution 3-96A was proposed to the MSMS House of Delegates by the Genesee County Medical Society, represented by Allen F. Turcke, MD. The resolution was studied by House Reference Committee F, which recommended the resolution be referred to the MSMS Board. The reference committee raised questions for which there were no answers at the time, and thus the Committee felt more study was needed. The two primary questions were whether there was precedent for MSMS as an association to join another association, and whether anything would be required or expected of MSMS should it join the National Association of Physicians for the Environment (NAPE).

Since the House, further information has been gathered in response to the questions. First, there is precedent for MSMS to belong to other associations. For instance, MSMS is a member of the Michigan Chamber of Commerce and the Alliance for Judicial Accountability. MSMS pays a fee to belong to both, and participates as it sees fit.

The same would be true of membership in the NAPE. The fee for membership in this organization is \$1,000. NAPE has been developed to work with the national medical specialties and subspecialties; with national, state and local medical societies and with individual physicians, to deal with the impacts of environmental pollutants on the organs, systems and disease processes best known to them.

The primary purpose of NAPE is to provide a forum for physicians to discuss medical environmental concerns. NAPE sponsors conferences on environmental health topics, to which MSMS could send representatives.

MSMS might be asked to send speakers to those conferences. There is no policy position or stand implied by membership in NAPE.

Other medical associations which currently are members of NAPE include the American Medical Association, Texas Medical Association, State Medical Society of Wisconsin, Pennsylvania Medical Society, American Academy of Dermatology, American Society of Hematology, American Society for Head and Neck Surgery, Society of Nuclear Medicine, American Academy of Otolaryngology, American College of Preventive Medicine, Michigan Otolaryngolocial Society and Genesee County Medical Society.

The Scientific and Educational Affairs Reference Committee of the Board was asked to study this Resolution 3-96A and make a recommendation to the Board. Committee members did not see overwhelming support nor great need for MSMS joining NAPE, which charges \$1,000 dues to organizations. As individual physician dues are just \$30, and as the AMA already represents organized medicine with NAPE, the Committee felt the more prudent approach would be to encourage individual physician involvement.

The MSMS Board of Directors concurs with the recommendation of the Scientific and Educational Affairs Committee and recommends that interested individual physicians be encouraged to join the National Association of Physicians for the Environment (NAPE), but the MSMS as an organization not join NAPE.

Reference Committee F on Scientific and Educational Affairs recommended Board Action Report #1 be approved.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #2 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 27-96A, "Restrict Availability of Over-the-Counter Nicotine"

RECOMMENDATION: That no action be taken on Resolution 27-96A, "Restrict Availability of Over-the-Counter Nicotine."

HOD Resolution 27-96A requested that MSMS seek legislation to restrict the over-the-counter sale of nicotine gum to minors; and to control the sale of nicotine gum to adults; and to ask the AMA to seek legislation to restrict the over-the-counter sale of nicotine gum to minors, to control the sale of nicotine gum to adults, and to study the long term addictive effects of non-tobacco nicotine products. This resolution was considered by the 1996 House of Delegates and referred to the MSMS Board of Directors for study. The Board subsequently assigned this resolution to the Committee on Michigan's Public Health for study and recommendation.

The Committee discussed this resolution as well as the need for the resolution. Committee members researched the cost of nicotine gum and patches and reported the following: for 7 packages of patches the cost was \$30, and for 48 sticks of 4 mg nicotrate gum the cost was \$35. Committee members believe that people get addicted to tobacco or smokeless tobacco not nicotrate gum especially at \$35 a pack. Nicotrate gum is packaged with a warning label that states it is not to be sold to anyone less than 18 years of age, and it has printed instructions on the label that identification is to be checked.

After much discussion, the committee recommended that the potential public health benefits of easy access to safe medication that can help people with smoking cessation out way the theoretical risks.

The MSMS Board of Directors concurs with the findings of the Committee on Michigan's Public Health and recommends no action be taken on HOD Resolution 27-96A.

Reference Committee E on Public Health recommended Board Action Report #2 be approved.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #3 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 28-96A, "Interstate Practice of Medicine"

Resolution 97-96A, "Full Michigan Licensing for Out-of-State Physicians Who Provide Medical Services to Michigan Residents via Telemedicine Services "

Resolution 98-96A, "Hospital Medical Staff Credentialing of Physicians Who Provide Electronic and Other Telemedicine Services for Hospital Patients"

RECOMMENDATION ONE: That the following Substitute Resolution for HOD Resolutions 28-96A and 97-96A be adopted:

RESOLVED: That MSMS seek legislation requiring that physicians treating patients who are within the state of Michigan be fully licensed by the state of Michigan regardless of the location the physician is practicing from or the procedure being performed or the modality of diagnosis or treatment;

RESOLVED: That legislation sought by MSMS specifically permit occasional and irregular medical consultations that are requested of physicians outside the state of Michigan who are not licensed in the state of Michigan.

RECOMMENDATION TWO: Adoption of HOD Resolution 98-96A which states:

RESOLVED: That MSMS support the requirement of physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients in a hospital setting within Michigan to be fully credentialed by that hospitals medical staff in accordance with the medical staff bylaws; and be it further

RESOLVED: That MSMS support the requirement of physicians who provide diagnostic or therapeutic services on a regular ongoing or contractual basis to patients in a hospital setting within Michigan solely via electronic or other distant communications (and so would not otherwise ever have any direct personal interaction with the remainder of the medical staff) be credentialed as active members of that hospital's medical staff and be held to the same standards of requisite responsibilities as other active members of the medical staff.

RECOMMENDATION THREE: That MSMS seek legislation requiring that a physician outside the state of Michigan treating a patient within the state, subject themselves to jurisdiction at the patients' location.

The Task Force on Interstate Medicine was established to review all aspects of interstate medicine ranging from scope of practice to telemedicine, and diagnosis of pathology specimens.

The Task Force on Interstate Medicine met on June 27, 1996, to discuss HOD Resolutions 28-96A, 97-96A and 98-96A, which were referred by the 1996 House of Delegates to the Board for study.

Primarily, Task Force members expressed their support of not limiting the occasional and irregular consultation privileges of physicians. However, members had unanimous support for legislation ensuring that patients within the state of Michigan are diagnosed and treated by a physician who is fully licensed to practice medicine in the state of Michigan regardless of the treating physician's location.

Current Michigan law does not explicitly define the practice of medicine across state lines. This discrepancy gives the Michigan Bureau of Occupational and Professional Regulation no authority or recourse when seeking disciplinary actions against non-licensed out-of-state physicians practicing medicine within the state of Michigan.

The Task Force was quite representative of all interested segments of medicine, and was able to reach a consensus that seeking legislation is the best means for addressing this issue. The Michigan Radiological Society and the Michigan Society of Pathology agree that legislation should be pursued as soon as possible.

The Board believes that this is a quality of care issue and that legislation is needed to ensure that Michigan citizens do not receive substandard care. The Board also believes that in order to level the playing field with physicians practicing outside the state, those physicians should subject themselves to jurisdiction at the patient location.

Reference Committee B on Legislation recommended approval of Board Action Report #3.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #4 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 31-96A, "Driver's with Suspended Licenses"

Resolution 35-96A, "Drunken Drivers' with Suspended Licenses"

RECOMMENDATION: That Resolutions 31-96A, "Drivers' with Suspended Licenses" and 35-96A, "Drunken Drivers' with Suspended Licenses" be supported in concept.

HOD Resolution 31-96A asks MSMS to seek legislation allowing for the impounding and or confiscation of motor vehicles being operated by individuals with suspended licenses. HOD Resolution 35-96A asks MSMS to seek legislation regarding the confiscation of privately owned vehicles by drivers with suspended licenses while driving under the influence of alcohol.

Both resolutions were discussed extensively at the 1996 House of Delegates, and ultimately referred to the MSMS Board of Directors for study. Delegates were not able to fully support the resolutions because they were unsure of the impact this would have on other family members using the vehicle for the purpose of driving to and from work, child care and other essential family matters. Also, delegates were unsure that this would achieve the goal of preventing certain individuals from driving. Therefore the 1996 House of Delegates referred the resolutions to the Board of Directors who referred the resolutions to the MSMS Committee on State Legislation and Regulations for study and recommendation.

The Committee discussed this matter in detail. Committee members expressed concern regarding the impact this type of law would have on the family member's ability to meet their financial and other needs. However, the Committee also believes that strong action is necessary to keep individuals with suspended driver's licenses off the roads. The potential harm to others by drunk driving out weighs the impact that impounding a car may have on the family. Therefore, the committee voted to support the resolutions in concept.

The MSMS Board of Directors concurs with the conclusions of the Committee on State Legislation and Regulations that MSMS should support legislation, but not seek such legislation due to the questionable effectiveness and possible side effects of such a law.

Legislation was introduced last session as a part of an overall drivers license reform package. The bill passed in December 1996 and took effect on March 31, 1997. Included in the legislation is a provision that allows a judge to order the confiscation of a vehicle owned by an individual convicted of driving under the influence. This new law accomplishes the objective of HOD Resolution 35-96A.

Reference Committee B on Legislation recommended Board Action Report #4 be

The House approved the recommendation of the Reference Committee.

ACTION REPORT #5 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 39-96A, "Medical Students Counted as Voting Members"

RECOMMENDATION: That MSMS medical student members be counted as full members when allocating the number of delegates for each county and that any and all resulting additional delegates be students; and that students not be counted as full members when allocating District Directors on the MSMS Board of Directors, and that the appropriate changes be made to the MSMS Bylaws.

HOD Resolution 39-96A requested that medical student members be designated as voting members of the Society and be counted as members when allocating the number of delegates for each county medical society and by each district for Board representation.

Current MSMS bylaws accord only one vote per medical school in the House of Delegates.

This resolution was first assigned to the MSMS Committee on Membership Recruitment and Retention. After considerable discussion and fact finding there, it was referred to the MSMS Task Force on Governance for a final recommendation.

The Task Force reviewed the Membership Committee's data and discussion and decided on the above compromise for several reasons.

First, the Task Force believes strongly that medical students are the future of organized medicine and that everything within reason and fairness must be done to help them become involved in MSMS and the AMA.

Second, if the goal truly is to get students involved in organized medicine and if the student count adds delegates to a county's delegation, then those new delegate positions must be filled by students.

And third, since the Task Force is recommending a slotted seat for students on the Board of Directors (see Action Report #8), its seems a fair and equitable compromise to add student representation to both the House and the Board without dramatically altering the status quo.

The MSMS Board of Directors concurs with the report of the MSMS Governance Task Force.

Reference Committee C on Internal Affairs and Public Service recommended Board Action Report #5 be disapproved.

The House disapproved the recommendation of the Reference Committee and voted to refer Board Action Report #5 to the Board for study.

ACTION REPORT #6 OF THE BOARD OF DIRECTORS

SUBIECT: Resolution 62-96A, "Laser Surgery by Doctors of Medicine and Osteopathy"

RECOMMENDATION ONE: That HOD Resolution 62-96A be referred to the Task Force on Scope of Practice Issues for appropriate study and final

RECOMMENDATION TWO: That MSMS seek to ensure that the practice of laser surgery be treated the same as the practice of surgery in accordance with Michigan law.

HOD Resolution 62-96A asks "that MSMS actively support efforts and legislation that promote laser surgery on humans to be performed exclusively by licensed doctors of allopathic medicine, osteopathy, podiatry and dentistry with proper training." This resolution was referred to the MSMS Board of Directors who referred it to the MSMS Committee on State Legislation and Regulations for study and recommendation.

The resolution was introduced to preempt efforts of many alternative health professionals (optometrists, cosmetologists, chiropractors) to perform laser surgery. The resolution was referred to the Board, because the House was not sure who to exempt from the legislation, optometrists are already prohibited from utilizing laser surgery, and was confused about the impact of further legislation.

Committee members generally expressed support for the resolution, however, believed that the newly formed MSMS Task Force on Scope of Practice issues would be a more appropriate forum to discuss and decide this issue. The task force will be evaluating the scope of practice for all allied and alternative health professionals, and will be in a better position to recommend who's scope of practice should include laser surgery.

The Board concurs that the MSMS/MAOPS Task Force on Scope of Practice issues is the appropriate venue to discuss this important issue. The Board also believes that this issues is of such importance that MSMS should express immediate support and seek to accomplish the objective of the resolution while it is concurrently being discussed by the Task Force.

Reference Committee B on Legislation recommended Board Action Report #6 be approved.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #7 OF THE BOARD OF DIRECTORS

SUBJECT: Resolution 69-96A, "Stability of Health Insurance Coverage and the Doctor/Patient Relationship"

RECOMMENDATION: That this report be adopted in lieu of HOD Resolution 69-96A, "Stability of Health Insurance Coverage and the Doctor/ Patient Relationship."

HOD Resolution 69-96A requested that MSMS work with the health insurance industry to mandate three year contracts for health insurance policies and that the Michigan Delegation to the AMA ask the AMA to do the same. This resolution was referred to the MSMS Board of Directors for further study. The Board of Directors subsequently referred it to the MSMS Advisory Committee on Medical Economics.

This resolution addresses the concern that health plans price their products low for the first year in order to get employers to sign on, only to increase the premium the following year. Facing this premium increase, the employer may choose to drop the plan, thereby disrupting the coverage of its employees and their ability to maintain an ongoing relationship with their physicians. The resolution does not call for legislative action, but instead seeks to address this issue by getting the insurance industry to set a minimum contract period of three years, which reduces the incentive to undercut competitors for a short term market increase. This kind of "voluntary mandate" would require the cooperation of the very entities that may be engaging in predatory pricing.

Employers seek to control their health care premiums wherever possible. The incentive to drop a plan after the premium is increased exists, although some employers may choose to pass the increased costs on to their employees. This puts the choice on employees to determine the tradeoff between stability of coverage and cost.

An outstanding issue is exactly who would be constrained by the contract period. If the health plans must offer three year contracts, they might

require that open enrollment periods be every three years as well, so that the patient pool could be guaranteed for the duration of the contract and premiums could be adjusted accordingly. This would further limit the ability of patients to switch from a plan if they were dissatisfied with the coverage, administrative burdens or choice of providers. Whether the constraint is on the employer, the employee, or both, the specification of a contract period would potentially punish the recipients for the business strategies of the entities providing the insurance coverage.

An alternative strategy would be to pursue corrective action as part of health plan regulation. There is some state oversight of HMOs, but PPOs, third party administrators, and self funded plans are relatively unfettered by state regulation or oversight. As with the changes that were included in the Patient Bill of Rights, it would begin to address the issues with certain types of plans. Dealing with the other types of plans requires much broader federal and state reform.

The Board concurred with the analysis of the issues involved in pursuing three year contracts for health insurance, particularly as they impact patient wishes to change plans. MSMS staff has been directed to raise the issue of length of insurance contracts for discussion with BCBSM, so that MSMS can continue to monitor the impact of changes in health care programs on continuity of care.

Reference Committee A on Medical Care Delivery recommended Board Action Report #7 be approved.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #8 OF THE BOARD OF DIRECTORS SUBJECT: Report from the MSMS Governance Task Force.

RECOMMENDATION ONE: That the MSMS Board of Directors be increased from 33 (26 District Directors and seven officers) to 36 (26 District Directors, seven officers and three slotted seats) by adding slotted seats for a young physician, a resident and a student. Additionally, all elections for District Directors and slotted seats will be held locally in advance of the House of Delegates and no "rubber stamp" vote will be taken at the House.

RECOMMENDATION TWO: That the unwritten rule for presidential rotation between Outstate and Wayne County, presently 2:1, be eliminated so that any MSMS member may run for president-elect in any year in a statewide contest.

RECOMMENDATION THREE: That no changes be made in the AMA Delegation election process at this time, but that the process be reviewed again prior to the 2000 House of Delegates. In the meantime, it is recommended that any "unwritten rules" governing AMA elections be written down and communicated to all MSMS members to clarify the process.

RECOMMENDATION FOUR: That the current rotation of Speaker and Vice Speaker between Outstate and Wayne County be eliminated and that the Vice Speaker automatically take over as Speaker if a vacancy occurs during the Speaker's term.

RECOMMENDATION FIVE: That all four officers of the Board of Directors, i.e., secretary, treasurer, assistant secretary and assistant treasurer, be nominated and elected by the Board rather than nominated by the Board and elected by the House; and that Article VII, Section 3, of the Constitution and Section 13.40 of the Bylaws be amended to reflect that change.

RECOMMENDATION SIX: That the above five recommendations, if adopted, not take effect until the House of Delegates in 2000.

RECOMMENDATION SEVEN: That the MSMS Governance Task Force continue its ongoing work and produce further reports for consideration prior to the year 2000 House of Delegates meeting.

Reference Committee C on Internal Affairs and Public Service recommended Board Action Report #8 be adopted as amended.

The House disapproved the recommendation of the Reference Committee on Recommendation One referred Recommendation One to the Board for study. The House approved the recommendation of the Reference Committee on Recommendations Two through Seven.

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Member, American Pain Society Member, American Academy of Pain Management

Dominick Lago, M.D.

Member, American Pain Society
Member, American Academy of Pain Management

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ACTION REPORT #9 OF THE BOARD OF DIRECTORS SUBIECT: Part-time Dues Category

RECOMMENDATION: That the following changes be made to the MSMS Constitutions and Bylaws on first reading:

Amend Section 2.00 "Membership—Classification—Election" to add:

2.50ACTIVE STATUS - PART-TIME DUES. A member who works more than four hours, but less than twenty hours per week may be placed in the part-time dues category. Dues for this category will be one-half the annual active membership dues rate. Members in this category will have all the privileges of active membership.

and that the appropriate numbering changes be made in Section 2.00.

At the 1994 House of Delegates, a resolution asking to create a part-time dues category was introduced. The part-time member was defined as a physician who worked more than four hours, but less than twenty hours per week. Dues for this category were set at one-half the annual active membership dues rate. The 1994 House of Delegates referred the resolution to the Board for further study.

In 1995, the Board recommended to the House that a part-times dues category be offered in 1996 and reviewed after two years. The House approved the offering of a part-time dues category on a two year trial basis. The House also directed the Board to further study the effect of this category on income and membership and if the category is judged effective, to recommend to the House appropriate change to the MSMS bylaws.

The Committee on Membership Recruitment and Retention has been monitoring the part-time dues category. The Committee has received favorable response to the new category and knows of 24 states, as well as the AMA, that offer this option for members. This option is available for physicians who may be entering practice or considering retirement. Currently, MSMS has 61 physicians using this membership category. Of those 61 physicians, a small percentage are new members to the Society. The larger percentage are physicians who are entering retirement and would probably have opted out of paying dues entirely through our retired membership category.

Those state societies offering this option believe the category has been a useful retention device and a positive force in recruitment solicitations. Most of MSMS' component societies have adopted the part-time dues category and believe it has worked well. The Ingham County Medical Society has introduced a resolution to create a permanent dues category for physicians working part-time.

The Committee believes that MSMS must seek innovative and flexible methods for physicians to remain active members of the Society, and has been pleased with the response to this effort.

The MSMS Board of Directors concur with the Committee on Membership Recruitment and Retention's assessment and recommend that this membership category become a permanent membership option.

Reference Committee on Constitution and Bylaws recommended Board Action Report #9 be approved.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #10 OF THE BOARD OF DIRECTORS SUBJECT: Recognition of Specialty Society

RECOMMENDATION: That the Michigan Chapter of the American College of Cardiology be recognized as a specialty organization, and that the appropriate changes be made to the MSMS Constitution and Bylaws on first reading

MSMS received a request from the Michigan Chapter of the American College of Cardiology for specialty society recognition by the MSMS House of Delegates. It has been determined that the Michigan Chapter of the American College of Cardiology meets the requirements for specialty society recognition as delineated in Section 20.20 of the MSMS Bylaws:

"Other specialty organizations that wish to be included in the list of recognized specialty organizations in this chapter must meet the following criteria: a) Be a statewide specialty organization at least five years old; b) have 25 or more active physician members of whom 70 percent or more maintain their membership in MSMS; and c) be approved by the House of Delegates

action, with the appropriate Bylaws amendments.

"A society must be statewide in scope, with a minimum of one meeting per year. In addition the governing body of the society must have taken formal action requesting delegate representation; i.e., sending a letter to the MSMS Board of Directors."

The Michigan Chapter of the American College of Cardiology was incorporated in 1989 (8 years old); is statewide in scope; and holds an annual business meeting in the fall of each year. The MSMS Department of Membership has confirmed that of the Chapter's 398 members 274 are MSMS members.

Reference Committee on Constitution and Bylaws recommended Board Action Report #10 be approved on the first reading.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #11 OF THE BOARD OF DIRECTORS SUBJECT: Resolution 88-96A, "Prostate Cancer Control Plan for Michigan"

RECOMMENDATION: That this report be adopted in lieu of HOD Resolution 88-96A, "Prostate Cancer Control Plan for Michigan."

Resolution 88-96A requested that MSMS endorse the goals of the Michigan Cancer Consortium and help support the professional education component of the Prostate Cancer Control Plan for Michigan thereby informing the physicians of Michigan of the findings and implications of the 1995 Michigan Prostate Consensus Conference on prostate cancer.

This resolution was referred to the Board by the 1996 House of Delegates for study. The Board referred the resolution to the MSMS Committee on Michigan's Public Health for further research and recommendation. The Committee believes that the intent of this resolution has been accomplished. The Committee also contacted Robert Bree, MD, author of the resolution and Doctor Bree agrees with this assessment.

MSMS participated in the development of the Michigan Prostate Cancer Consensus Conference and has offered the Michigan Prostate Cancer Consensus Conference statements and recommendations for further study to its members through *Medigram*.

The Michigan State Medical Society will continue to work with the appropriate agencies and organizations to address this and other important cancer related issues.

The MSMS Board of Directors concurs with the report of the Committee on Michigan's Public Health and recommends adoption of this report in lieu of House of Delegates Resolution 88-96A.

Reference Committee E on Public Health recommended Board Action Report #11 be approved.

The House approved the recommendation of the Reference Committee.

ACTION REPORT #12 OF THE BOARD OF DIRECTORS SUBJECT: COMMENDATION OF LEADERSHIP AND STAFF

RECOMMENDATION: That the MSMS House of Delegates commend: Krishna K. Sawhney, MD, Chair, MSMS Board of Directors Kenneth H. Musson, MD, Vice Chair, MSMS Board of Directors William E. Madigan, MSMS Executive Director

Kevin A. Kelly, MSMS Managing Director, and all the staff of MSMS for their astute leadership and unswerving dedication to MSMS resulting in a year of remarkable progress for the physicians of Michigan.

Reference Committee C on Internal Affairs and Public Service recommended Board Action Report #12 be approved.

The House approved the recommendation of the Reference Committee.

Speakers' Report

Taking action on 1996 MSMS resolutions

By Dorothy M. Kahkonen, MD, Speaker Paul O. Farr, MD, Vice Speaker

During the past year, MSMS committees, Board and staff worked diligently to turn the 1995 resolutions into actions. Following are the results:

1-96A Title: Continuing Medical Education (CME) Fees for Retired Physicians. No Action.

2-96A Driving Under the Influence Penalty. No Action.

3-96A Title: MSMS to Join the National Association of Physicians for the Environment. Referred to the Board for Study.

This resolution asked that MSMS join 32 other county, state and national medical organizations in a paying membership in the National Association of Physicians for the Environment.

The resolution was referred to the Board, which in turn asked its Scientific and Educational Affairs reference committee to study and act on the resolution. The Committee obtained background information on the national organization. After deliberation at their September meeting, the committee recommended, and the Board agreed, to encourage MSMS members to join the organization individually if they are so inclined. MSMS publications will carry out the Board's wishes. The Board did not favor paying the \$1,000 organizational dues to NAPE.

4-96A Title: Amendments to the MSMS Hospital Medical Staff Section Bylaws. Adopted as Amended.

This resolution asked the MSMS House of Delegates to approve changing the name of the MSMS Hospital Medical Staff Section to the MSMS Organized Medical Staff Section.

Resolution 4-96A was approved changing the name of the HMSS to the MSMS Organized Medical Staff Section. This name change was effected by the MSMS/OMSS governing council in all of its communication and activities. Generated from resolution 4-96A is resolution 5-97A title "Amendments to the MSMS Hospital Staff Section Bylaws." This resolution calls for changes to the MSMS/HMSS bylaws and recommends that amendments to the MSMS Bylaws be considered during the 1997 House of Delegates, and if approved, take immediate effect.

5-96A Title: Education Programs on Professional Contracting. No Action.

6-96A Physician Membership on Hospital Governing Bodies. Adopted as Amended.

This resolution asked MSMS to encourage all physicians to participate in their health organizations' governing bodies and asked MSMS to encourage the Michigan Health and Hospital Association to make known to its member hospitals the importance governing bodies bring to membership, both Corporate Affiliated Physicians and physicians in the traditional private practice of medicine. The resolution also asked MSMS to make available to its members educational sessions pertaining to various aspects of hospital financial and operational management, and that this be provided at a reasonable fee with the appropriate category of CME credit.

The MSMS/OMSS Governing Council has made known to the Michigan Health and Hospital Association the importance governing bodies bring to membership in Corporate Affiliated Physicians (CAPS). The Governing Council supported the position and advised the MIchigan Health and Hospital Association regarding the importance of physician membership in not only an ex officio capacity but as a regular member of the governing

bodies of hospitals and to this end, the Department of Physician Hospital Relations has begun an inventory of Michigan Hospital Governing body membership. Regarding the third Resolved, the Governing Council with the Department of Physician Hospital Relations developed the 1996 Hospital Financial Information in Brief report which has been distributed to Chiefs of Medical Staffs, OMSS Representatives, Hospital Presidents/CEOs, and all MSMS members requesting a copy of their MSMS District information.

7-96A Title: Specialty Society Status for the American Sleep Disorders Association in the AMA House of Delegates. Approved.

This resolution asked the Michigan Delegation to ask the AMA to approve the American Sleep Disorders Association's (ASDA's) request for an AMA House of Delegates specialty society seat.

The AMA House of Delegates in June approved the bids of 11 specialty societies for representation in the House. The ASDA was among the successful bidders. There was no opposition to the ASDA's seat in the AMA House; rather, there was considerable favorable testimony for increasing representation and the positive membership effects that would result.

8-96A Title: Establishment of a Physician Services Organization. Substitution Board Action Report #10 (in lieu of 8-96A, 74-96A and Board Action Report #1). See Board Action Report #10.

9-96A Title: Health Care Service Corporation Commendation. Approved.

This resolution commended the Health Care Service Corporation of Illinois and it's medical director, Geroge R. Gerber, MD, for service improvements as the Medicare intermediary for Michigan.

A framed copy of the resolution was sent to the Health Care Service Corporation of Illinois and presented to Doctor Gerber at the November 14, 1996, meeting of the MSMS Laison Committee with Third Party Payers.

10-96A Title: Gag Orders and Hold Harmless Clauses Contained in Managed Care Contracts. Substitute Resolution (in lieu of 10-96A, 18-96A and 36-96A). Adopted.

This resolution calls for MSMS to advise members on the identification of gag orders and hold harmless clauses in managed care contracts and to seek legislation prohibiting their use.

Through seminars, presentations and publications, MSMS continues to advice members about these and other contract clauses that are potentially harmful. MSMS also continues to solicit from members information about plans that include gag orders in their contracts. Both the American Association of Health Plans and its Michigan branch oppose use of gag orders and have asked to be alterted is gag orders are found. In Michigan, most plans include a hold harmless clause, and MSMS continues to advise members to be vigilant in identifying themselves and seeking their removal.

Regarding gag orders, the Michigan House of Representatives unanimously approved House Bills 4392 through 4394, which prohibit gag rules. The bills now await action by the Senate Health Policy Committee. MSMS is currently seeking a sponsor for legislation to prohibit hold harmless clauses.

At the close of the 1996 session no state legislation passed that would prohibit the existence of gag clauses in health care contracts. However, House bills 4392-4394 were introduced in March 1997, which specifically prohibits the use of gag clauses in health plan contracts. The legislation was introduced by Rep. Joe Palamara, (D-Wyandotte, Chair, House Health Policy Committee), Rep. Mary Schroer, (D - Ann Arbor), and Rep. Mark Schauer (D - Battle Creek). The legislation unanimously reported out of the House Health Policy Committee and passed the Michigan House of Representatives on March 18, 1997. The legislation is expected to be taken up in the

Senate Health Policy Committee by the time the 1997 House of Delegates

The second resolved of this resolution asks that MSMS seek legislation prohibiting managed care organizations (MCOs) from imposing any form of gag orders, hold harmless clauses, and pejorative treatment arising out of such contractual stipulations.

MSMS is currently working to seek passage of House Bills 5570-5574, the Michigan Patient Bill of Rights which includes legislation prohibiting MCOs from imposing any form of gag orders, hold harmless clauses or pejorative treatment arising out of contractual stipulations.

However, HB 5987 was recently introduced by Representative Mary Schroer, D-Ann Arbor. The legislation prohibits health maintenance organizations from limiting health professionals' discussion with patients and others about certain coverage and treatment options. It is unlikely that this legislation will move forward this session, however, other lawmakers have expressed an interest in the important issues of gag orders, hold harmless clauses and other pejorative treatment arising out of contractual stipulations.

The third and fourth resolveds of this resolution call on the Michigan Delegation to the AMA to support AMA efforts to seek legislation prohibiting managed care organizations from imposing gag orders to prevent physicians from discussing quality of care issues with their patients, and to seek legislation making managed care organizations primarily liable for pejorative treatment arising out of gag orders enforced upon contracted physicians.

The Michigan Delegation introduced this resolution at the June 1996 AMA Annual Meeting, where it was approved, without debate, on the affirmation calendar.

This resolution has been referred to the AMA Council on Medical Service for follow-up.

11-96A Title: Designation of Primary Service Providers (PSP) for Medicaid Patients. Approved.

This resolution requested MSMS to study the problem of the Michigan Department of Community Health's Medical Services Administration (MSA) arbitrarily assigning a physician for patients who fail to designate a Primary Service Provider (PSP) in a timely manner.

This resolution has been discussed at various Medicaid Liaison Committee meetings, where physicians have clearly questioned the arbitrary assignment policy. The MSA has indicated that they are making every effort to give the patients the opportunity to select the physician of their choice. In regards to the problem of the MSA designating patients with providers of the wrong specialty to meet the patient's needs (i.e. designating an adult with a pediatrician or a male with an OB/GYN), MSA has acknowledged difficulty in determining a physician's specialty as a result of not having the right technology to do so. The MSA also acknowledged that they would do what they can to further address these problems. Most significantly the Michigan Department of Community Health has announced its intention to phase out the Physician Sponsor Plan and replace it with a capitated model, including contracts with HMOs and physician organizations.

MSMS continues to work closely with Robert Smedes, CEO, MSA, and his staff in the new capitated Medicaid managed care initiative. The state is no longer arbitrarily assigning patients to physicians within the PSP program as of August 1, 1996.

12-96A Title: Uniform Claim Standards. Approved.

The resolution seeks legislation to require use of an appropriate billing form and called on MSMS to study the problem of multiple post billing requests by insurers.

In 1996, MSMS strongly supported HB 4903-4907, which would require health plans to utilize universal claims standards. The MSMS Subcommittee on Universal Claims Standards met with the House Insurance Committee Subcommittee on Universal Claims Standards to urge them to support HB 4903-4907. In addition, the bills were amended to include the specific recommendations of MSMS. Several hearings took place regarding this matter and discussions among various interest groups also took place.

House Bills 4903-4907 did not pass by the end of the 1996 legislation session. However, several lawmakers including, Rep. Sharon Gire, (D Clinton Township), have indicated their interest in seeking legislation requiring the use of universal claims standards. MSMS will continue to seek passage of this legislation this session.

Through contacts with our Reimbursement Onbudsman, MSMS is able to document issues where significant additional documentation is required



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and, in many cases, can work with payers to persuade them to adopt more user-friendly approaches. MSMS also will identify special problems in this area and continue to refine recommendations for standardized billing procedures so that they can be incorporated into recommendations to legislators and insurers.

13-96A Title: Arbitrary Discount of Professional Fees for Medical Services by Automobile Insurance Companies. Approved.

This resolution seeks examination of the dimensions and impacts of arbitrary discount of professional fees by automobile insurance carriers.

MSMS review of this issue suggests that most decisions are made by utilization review firms under contract with the insurer. Legislation has been introduced to mandate use of certain standards by utilization review organizations and by insurers who conduct review. MSMS will share information about the specific impact on auto insurer decisions relating to trauma care in our pursuit of passage of this legislation.

Title: Pending Status of Payment for Medicaid Approved Procedures. Adopted as Amended.

This resolution asked that MSMS request an accounting from the Michigan Medicaid Program with specific information of claims pending including an age analysis and analysis by specialty and that the findings be reported to its membership via Michigan Medicine.

MSMS continues to work closely with the Medical Services Administration (MSA) to obtain this information. Currently Medicaid's computer system cannot identify a patient's age or date of birth.

15-96A Title: Identification and Review of Standard Exclusions in Health Insurance Contracts. Approved.

The resolution seeks examination of standard exclusions in health insurnace contracts and the impact of these exclusions on quality of care.

A review of contracts suggests common exclusions are for services related to pre-existing conditions and screening or preventive services, and office visits. Legislation to limit the extent to which pre-existing conditions can be excluded from coverage was adopted in 1996, through the Michigan Patient Bill of Rights. This year, Michigan's largest insurer, Blue Cross Blue Shield of Michigan, began offering a new PPO program, Community Blue, that provides coverage for many office, screening and preventive services previously not covered through Blues traditional programs. MSMS will continue to identify exclusions that impact quality of care and continue efforts to persuade purchasers, who make decisions about benefits, to consider long term cost and quality implications of certain exclusions.

16-96A Title: Identification of Quality of Care Concerns Caused by the Demands of Third Party Payers and Regulatory Agencies. Adopted as Amended.

This resolution asked that MSMS find a mechanism by which it can act as a clearinghouse for guidelines and benchmarks to assist managed care payers and regulatory agencies in dealing with these quality of care con-

A Subcommittee on Practice Guidelines chaired by Brian McCardel, MD, has been appointed to explore the various options available to MSMS in carrying out this resolution. The subcommittee will continue to meet in the coming year to further refine and implement a list of options compiled in a brainstorming session.

17-96A Title: Advise Physicians Regarding the Importance of Organized Medicine. Adopted of Amended.

This resolution requested MSMS to educate Michigan physicians regarding the value of membership in county medical societies, MSMS and the AMA; encourage physicians to become associate members in counties where they may reside but not practice medicine; and encourage the AMA to continue its assertive membership recruiting efforts. The resolution also directed the Michigan Delegation to the AMA to ask the AMA to continue to educate physicians regarding the value of membership in their county, state and national medical associations, and to ask the AMA to continue its assertive membership recruiting efforts.

Since the 1996 MSMS House of Delegates MSMS has sent personalized solicitations to 1,035 physicians in the state, responded to 351 application requests and completed two large nonmember solicitations (total 5,400) to IMG's, and women physicians. MSMS also developed a joint solicitation regarding MPMLC insurance to physicians (3,545) in Oakland County and District Three. In each solicitation the benefits and services of organized medicine at all three levels were addressed in thorough detail.

The 1997 dues billing also includes information regarding MSMS, the AMA, and county society strategies which allow physicians to maintain control of their practice while providing them with practical tools for effective decision making.

MSMS will remain steadfast in its aggressive recruitment efforts as well continue to work closely with the AMA on recruitment and retention in 1997 and beyond.

MSMS will also encourage physicians to consider associate membership in counties where they reside, but may not actually practice.

The Michigan Delegation to the AMA has forwarded this resolution by letter in October to P. John Seward, MD, AMA Executive Vice President requesting action.

18-96A Title: Hold Harmless Clauses in Managed Care Organizations (MCOs) Contracts. Substitute Resolution (in lieu of 10-96A, 18-96A and 36-96A) Adopted. See Resolution 10-96A.

19-96A Title: Evaluate the MSMS Board of Directors Election Process. Substitute Resolution (in lieu of 19-96A, 64-96A and 81-96A) Adopted.

This resolution asked the MSMS Speaker of the House of Delegates and the Chair of the Board of Directors to appoint an ad hoc committee with wide representation from component county medical societies, specialty societies and the MSMS sections. The resolution also asked the ad hoc committee to review the governance of MSMS, evaluate the role of county medical societies and whether members are getting value for their dues, review the distribution of Michigan delegates to the AMA and to present a report and recommendations to the 1997 House of Delegates.

The Comittee met on December 17, 1997; January 29, 1997; and February 26, 1997. During the first two meetings, the Task Force asked for and received considerable input from county society presidents, district delegation chair and county executives. The last meeting was for task force members only to make the final recommendations.

The task force recommended that the MSMS Board of Directors be increased from 32 (26 District Directors and seven officers) to 36 (26 District Directors, seven officers and three slotted seats) by adding slotted seats for a young physician, a resident and a student. Additionally, all elections for District Directors and slotted seats will be held locally in advance of the House of Delegates and no "rubber stamp" vote will be taken at the House. If adopted, this resolution would not take effect until the House of Delegates in 2000.

This recommendation resulted from considerable discussion about the size and composition of the MSMS Board of Directors. One of the primary goals of Task Force Members and those testifying was to increase representation of younger members, the one area all agreed was lacking on the present Board. Various ways to reduce the Board size to allow creation of slotted seats were debated, including redistricting, combining smaller districts and increasing the ratio of district members to Board members. All were rejected a unacceptable to one group or another. Instead, the task force recommended simply adding three new slotted seats for a young physician, a resident physician and a medical student. Rules for electing each will be promulgated before these recommendations take effect.

Title: Seat Belt Usage. Adopted as Amended.

The first resolved of this resolution asked MSMS to endorse the proposed Michigan legislation to achieve the greatest protection of persons through primary enforcement of seat belt use.

House Bill 5000, which established primary enforcement of the seatbelt law did not pass the legislature by the end of the 1996 legislation session. However, the Seatbelt Coalition renewed its efforts to seek passage of legislation in 1997. House Bill 4280, was introduced by Rep. Frank Fitzgerald (R - Grand Ledge) and was kicked off with a significant seatbelt press conference. W. Peter McCabe, MD, is the current co-chair of the Michigan Seatbelt Coalition. Doctor McCabe spoke eloquently, and effectively at the kickoff press conference. A hearing is scheduled for April in the House Transportation Committee. It appears that a great deal of effort is needed in order to pass this important legislation.

The second resolved of this resolution asks the Michigan Delegation to the AMA to ask the AMA to compile and disseminate available data on the effect on the human body of seat belt and/or airbag use, as well as child and infant restraining devices, in automobile accidents at various speeds.

The Michigan Delegation to the AMA forwarded this resolution to the 1996 AMA Interim Meeting in Atlanta.

Title: Young Physicians Section (YPS) Survey. Adopted.

This resolution asked MSMS to conduct a new survey of young physician members and nonmembers and share the results with MSMS members, committees and county medical societies.

In 1991, MSMS conducted a survey of young physicians that focused on what skills they learned in medical school and residency and in which areas they would have liked more backgound prior to starting practice. The areas that they felt unprepared for included billing and coding, managed care issues, and other business aspects of running a practice. Medical schools and residencies are recognizing these needs and are making small modifications in their curriculum to reflect these needs, and national, state, county and specialty societies also offer programs of use.

MSMS staff have met with the Young Physician Section (YPS) Governing Council to discuss what issues they would like to focus on in the new young physician survey. The survey itself has been delayed until summer of 1997 so as not to compete with the biennial Survey on Practice Characteristics, which went out to all actively practicing members in November 1996.

After the results of that survey are released in May, final plans will be made for the YPS survey. A nonmember survey is also under development, and specific questions for young physicians will be included in a targeted mailing to that group of members. Results from both of these surveys will be available in fall 1997 and will be widely distributed to the membership.

22-96A Title: Recycling at the MSMS Joint Section Meeting and MSMS House of Delegates. Approved.

This resolution called for recycling bins to be made available and placed in a prominent position at both the Joint Section Meeting and House of Delegates and for leadership to remind attendees to use the bins.

The MSMS House of Delegates will continue to recycle materials as it has been for the past three years by placing bins at the back of the main meeting room for use on the final day of the meeting. At the opening session of the House of Delegates, the Speaker reminds those attending to utilize the recycling bins. The Joint Section meeting will have recycling bins available for use beginning with their February 28, 1997, meeting.

23-96A Title: MSMSNET and Electronic Communications. Adopted as Amended.

This resolution called for MSMS to solicit but not require e-mail addresses as part of the application process for society membership, and that these addresses be available for use by the members in a secured form so that cost-efficient messages can be transmitted to the membership between members on a timely basis.

As part of the normal application process, MSMS now asks for e-mail addresses. The MSMS member database is constantly being enhanced by a registration utility on MSMSNET that requires visitors to the homepage to submit their name and e-mail address. E-mail address information will be published in the next MSMS Membership Directory, thereby distributing this communication information to the appropriate parties. The MSMS membership directory will be available in August 1997.

24-96A Title: Development of a Guide to the Internet. Adopted as Amended.

This resolution calls for MSMS in conjunction with MSMS Young Physician Section, MSMS Resident Physician Section, and the Committee on Technology in Medicine to create a "basic and brief" guide to the Internet. The resolution calls for this guide to be available in both electronic and

On January 22, 1997, the Committee on Technology in Medicine approved a printed guide to the Internet prepared by MSMS staff. This guide includes sections on an Introduction to MSMSNET, What is the Internet, Installation and Configuration, Using Netscape Navigator and Using Netscape E-Mail. MSMS is currently reviewing distribution options for the printed guide, and is to launch an electronic MSMSNET version of the document on May 1, 1997.

Title: Mentor Program for Young Physicians at the County 25-96A Medical Society Level. Approved.

This resolution asked MSMS to work with the Young Physicians Section (YPS) to develop a "peer mentor" program for young physicians at the county medical society level and to use this program to cultivate young physician involvement in organized medicine.

The Young Physicians Section Governing Council is currently developing information and material for county medical societies to use in working with young physicians in their area. MSMS will also help counties identify

young physicians in their counties, as well as the unique benefits and services that organized medicine has to offer.

Title: The Impact of Alcohol and Tobacco Advertisement 26-96A to Minors. No Action.

27-96A Title: Restrict Availability of Over-the-Counter Nicotine. Referred to the Board for Study.

This resolution asked MSMS to seek legislation to restrict the over-thecounter sale of nicotine gum to minors and to control the sale of nicotine gum to adults.

This resolution was referred to the MSMS Board of Directors for further study. The MSMS Board of Directors then referred this resolution to the MSMS Committee on Michigan's Public Health. The MSMS Committee on Michigan's Public Health reviewed this resolution at their February 5, 1997, meeting.

Committee members did not see Nicorate gum as a threat for causing nicotine addiction. Nicorate gum is packaged with a warning label that states it is not to be sold to anyone less than 18 years of age and it does have instruction on it that it is to be checked. Nicorate gum and patches are packaged seven patches for \$30.00, and 48 sticks of 4 mg nicorate gum for \$35.00.

After a great deal of discussion the committee recommended that the Board of Directors take no action on Resolution #27-96A, "Restrict Availability of Over-the-Counter Nicotine.

This recommendation was approved by the MSMS Board of Directors at their March 5, 1997, meeting.

28-96A Title: Interstate Practice of Medicine. Referred to the Board for Study.

This resolution asked MSMS to seek legislation mandating that a primary medical diagnosis and treatment of any patient in Michigan be provided only by or under the direct supervision of a licensed health care professional with a full and unrestricted Michigan medical license, and that MSMS oppose the concept of granting limited licenses allowing non-Michigan physicians to practice medicine across state lines to Michigan.

The Task Force on Interstate Medicine was established to review Resolutions 28-96A, 97-96A and 98-96A, which were referred to the Board for further study. The Task Force on Interstate Medicine met on June 27, to discuss this issue and forwarded its recommendations to the MSMS Board of Directors at its Midsummer Board meeting.

The MSMS Board of Directors approved the recommendations of the Task Force which supports legislation requiring that physicians treating patients who are within the state of Michigan be fully licensed by the state of Michigan regardless of the location the physician is practicing from or the procedure being performed or the modality of diagnosis or treatment. Legislation sought by MSMS would specifically permit occasional and irregular medical consultations that are requested of physicians outside the state of Michigan who are not licensed in the state of Michigan.

In addition, MSMS supports the requirement of physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients in a hospital setting within Michigan to be fully credentialed by that hospital's medical staff in accordance with medical staff bylaws. Furthermore, these services within Michigan that are provided solely via electronic or other distant communications be credentialed as active members of that hospital's medical staff and be held to the same standards of requisite responsibilities as other active members of the medical staff.

The Board of Directors further recommended that MSMS seek legislation requiring that a physician outside that state of Michigan treating a patient within the state, subject themselves to jurisdiction at the patient's location. MSMS continues to work with the Michigan Radiological Society and the Michigan Society of Pathologists in order to seek introduction of legislation in 1997.

29-96A Title: Legislative Database. Substitute Resolution. Adopted.

This resolution asked MSMS to compile a database of votes cast by the Michigan legislature related to issues on which MSMS has a stated position, and that MSMS provide the database to the membership in a timely fashion prior to elections so physicians can determine the degree of support for their elected officials.

MSMS is currently working with Public Sector Consultants (PSC), Inc.,

to successfully accomplish this objective. PSC tracks legislation and measures meaningful levels of a legislator's support regarding those issues on

which MSMS supports or opposes.

MSMS and PSC are formulating a system by which votes cast by each and every legislator can be tracked, recorded, and organized. Concern over the complexity of some amendments/provisions to legislation were also addressed. MSMS will also track those bills which legislators sponsored or cosponsored that affect physicians. This would provide MSMS a means of differentiating individual lawmakers in sessions when there are few controversial health-related bills voted on.

The second resolved of this resolution asked the Michigan Delegation to the AMA to ask the AMA to provide a database on Congressional votes regarding issues on which organized medicine has a stand, and to provide

the data to the membership in a timely fashion.

The Michigan Delegation introduced this resolution at the June 1996 annual meeting of the AMA House of Delegates, where it did not pass. There was much testimony against such a database, because raw vote data can be misconstrued or pulled out of context to create problems for the AMA. There was support for the AMA's current close cooperation with the state societies in evaluating elected officials' performance and sensitivity to organized medicine's issues.

30-96A Title: Specialists Who Are Not Board Certified. No Ac-

31-96A Title: Drivers With Suspended Licenses. Referred to the Board for Study

This resolution asked MSMS to seek legislation allowing for the impounding and or confiscation of motor vehicles being operated by individuals with suspended licenses.

This resolution was discussed extensively at the House of Delegates, and referred to the MSMS Board of Directors for study which referred it to the

MSMS Committee on State Legislation and Regulations.

The Committee discussed this matter in detail. Committee members expressed their concern regarding the impact this type of law would have on the family member's ability to meet their financial and other needs. However, the Committee also believes that strong action is necessary to keep individuals with suspended driver's licenses off the roads. The potential harm to others by drunk driving out weighs the impact that impounding a car may have on the family. Therefore, the committee voted to support the resolution in concept.

The MSMS Board of Directors concurs with the conclusions of the Committee on State Legislation and Regulations that MSMS should support legislation, but not seek such legislation due to the questionable effectiveness

and possible side effects of such a law.

Legislation being sought by the resolution was introduced last session and may be reintroduced this session.

32-96A Title: Physician Participation in Educational Programs for Total Care Patient Management. No Action.

33-96A Title: Disaffiliated Physicians. No Action.

Title: Drivers License Suspensions. Approved. 34-96A

This resolution requested MSMS to ask the Secretary of State to issue guidelines for the assessment of a driver's competence because of a medical illness, an emotional disorder, medications and/or alcohol or illicit drug abuse and that these guidelines include due process to protect individuals' driving privileges and that the persons' health records are not made public.

Michigan's Secretary of State has a Vehicle Code Book, which can be purchased from the Contracts Office for \$16.00 at (517) 373-2570. This book has established guidelines for assessing a driver's competence due to medical or mental illness. Persons' health records are not attainable by the public.

35-96A Title: Drunken Drivers with Suspended Licenses. Referred to the Board for Study.

This resolution asked MSMS to seek legislation regarding the confiscation of privately owned vehicles by drivers with suspended licenses while dring under the influence of alcohol.

This resolution was discussed extensively at the House of Delegates, and referred to the MSMS Board of Directors for study who referred it to the MSMS Committee on State Legislation and Regulations.

The Committee discussed this matter in detail. Committee members

expressed their concern regarding the impact this type of law would have on the family member's ability to meet their financial and other needs. However, the Committee also believes that strong action is necessary to keep individuals with suspended driver's licenses off the roads. The potential harm to other by drunk driving out weighs the impact that impounding a car may have on the family. Therefore, the committee voted to support the resolution in concept.

The MSMS Board of Directors concurs with the conclusions of the Committee on State Legislation and Regulations that MSMS should support legislation, but not seek such legislation due to the questionable effectiveness

and possible side effects of such a law.

Legislation was introduced last session as a part of an overall drivers license reform package. The bill passed in December 1996 and took effect on March 31, 1997. Included in the legislation is a provision that allows a judge to order the confiscation of a vehicle owned by an individual convicted of driving under the influence.

36-96A Title: Gag Orders Imposed on Physicians by Managed Care Organizations (Mhos). Substitute Resolution (in lieu of 10-96A, 18-96A and 36-96A). See Resolution 10-96A.

37-96A Title: Weakening Handgun and Assault Weapon Regulations. Approved

This resolution asked MSMS to oppose any legislation that would weaken the current laws regarding the manufacture, importation and/or ownership

of assault weapons and/or handguns.

MSMS worked with various organizations to defeat legislation which would potentially make it easier for an individual to acquire a concealed weapons permit. Emergency room physicians testified in opposition to this legislation, warning that this type of legislation presented a clear danger to the public health of Michigan citizens. The bills did not receive the necessary votes to be reported out of committee.

Legislation which would have made it easier for an individual to acquire a concealed weapon permit did not pass during that 1996 legislation session. As of March 15, 1997, legislation has not been introduced which would accomplish the same objective. However, it is expected to be introduced at

some point this session.

38-96A Title: Financial Disclosure for Health Insurance Companies. Approved.

This resolution asked MSMS to seek legislation requiring all health insurance companies operating in this state to annually send their subscribers a breakdown of expenses for the previous year. The resolution further asked MSMS to seek provisions in this legislation to include in this report the percentage of gross revenues as well as real dollar amounts spent on executive salaries, advertising, promotion and sponsorship of public as well as the amount of money spent directly to reimburse the subscribers actual health

MSMS along with the Michigan Partners to Patient Advocacy were successful in seeking passage of the Michigan Patient Bill of Rights, which included a provision requiring health plans to inform enrollees of all pertinent information regarding their health plan. The legislation also required health plans to offer a toll free number to enable individuals to ask for additional information regarding their plans. House of Delegates Resolution 38-96A would take the information required of health plans on step further, by requiring very specific information regarding financial situation, which is traditionally submitted only to the Insurance Bureau and the Michigan Department of Community Health. The Michigan Partner for Patient Advocacy Coalition recently met to discuss their legislative initiatives for 1997 and included in those initiatives an effort to expand the information provided to patients. Also the coalition will seek legislation to require that the information be provided to any individual who requests it, not only those already enrolled in the plan. MSMS and the Michigan Partners for Patient Advocacy will seek to require health plans to disclose this specific financial information called for in House of Delegates Resolution 38-96A. We expect legislation to be introduced in 1997 in order to accomplish these objectives.

39-96A Title: Medical Students as Counted Members of MSMS. Referred to the Board for Study.

This resolution asked MSMS to change its bylaws to include medical students as counted members for the House of Delegates. Current MSMS policy does not consider medical students as "voting" members of the society and therefore are not counted by the society when determining the number of delegates for the MSMS House of Delegates from each county.

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MSMS is currently collecting information from each state medical society regarding their specific policy on medical students. The information will be compiled and reviewed by the Committee on Membership Recruitment and Retention then sent to the MSMS Board of Directors. If medical students are to be included as voting members of the society a change in the MSMS Constitution and Bylaws will be necessary.

The AMA does include students as voting members of the association and they are encompassed in the numbers when the AMA determines the exact number of delegates awarded to each state based on AMA membership in the individual state.

40-96A Title: Immunizations Without Liability Hazard. No Action.

41-96A Title: Examination for State Re-Licensure. Adopted as

This resolution asked that MSMS oppose mandatory examination for re-licensure by the State of Michigan except re-licensure after forfeiture of the original license.

The State of Michigan re-licensure guidelines do not require a mandatory examination. Current criteria for re-licensure includes standard fees for a controlled substance license as well as the Michigan Board of Medicine standard license. In addition, physicians must complete a minimum of 150 continuing medical education (CME) credits prior to re-licensure which takes effect January 31, three years following the initial granting of the license. MSMS strongly encourages physicians to keep their corresponding address up to date with the State of Michigan to ensure timely re-licensure standards. Current Michigan law states that physicians must inform the Board of Medicine, in writing, within 30 days of any change in this information.

42-96A Title: Support of Cost Control Mechanisms. Disapproved.

43-96A Title: MSMS Merit Award for Distinguished Service. Substitute Resolution (in lieu of 43-96A, 44-96A and 46-96A). Adopted.

This resolution asked MSMS to establish and set criteria for a Merit Award for distinguished service by members at the sate and county levels of organized medicine, and that this Merit Award be named in the honor of the late Charles C. Vincent, MD.

MSMS staff is currently reviewing the criteria of all other MSMS awards and special awards presented by the American Medical Association and other professional organizations in an effort to determine the best criteria for the merit award to be known as the "Charles C. Vincent, MD, Distinguished Service Award." Criteria and nominating procedures will be reviewed by the MSMS Board of Directors at the Mid-Summer Board Meeting.

44-96A Title: Gerald H. Mandell, MD, President-for-a-Day. Substitute Resolution (in lieu of 43-96A, 44-96A and 46-96A). See Resolution 43-96A.

Title: Identification at MSMS House of Delegates. Adopted.

This resolution asked the MSMS House of Delegates Speakers to require all speakers from the floor at the meeting to identify themselves by name, county, and whether speaking as an individual or representative of a

county, specialty society or corporate entity.

The MSMS House of Delegates Speakers already request and will continue to request before the beginning of each meeting of the House that all speakers from the floor must identify themselves by name and official affiliation such as county medical society, specialty society, section, corporate entity or Board member. The Speakers immediately interrupt anyone speaking from the floor of the House who fail to identify themselves and remind them to give their name and affiliation. This information is also given by the Speakers at the New Delegates Reception held prior to the opening of the House of Delegates and is also included in the welcome brochure given to all attendees prior to the House of Delegates meeting.

46-96A Title: Charles C. Vincent, MD, President-for-a-Day. Substitute Resolution (in lieu of 43-96A, 44-96A and 46-96A). See Resolution 43-96A.

47-96A Title: Health Maintenance Organizations (HMOs) and Managed Care Advertising/Commercials. Approved

The resolution requested MSMS to call upon HMOs to cease advertising that their participating physicians are the best available.

Although most health plans appropriately maintain that their physician

network is a good marketing tool, MSMS has requested that at least two Michigan plans cease ad campaigns that were particularly offensive in suggesting that non-participating physicians did not provide the same quality of care. Both plans have replaced the ads with different approaches and MSMS will continue these efforts.

48-96A Title: Blue Cross Blue Shield of Michigan (BCBSM) and Medicaid Correspondence. Adopted as Amended.

This resolution asked MSMS to request BCBSM and Medicaid to use proper professional titles in communicating with physicians.

This request has been transmitted, and BCBSM mailings for some programs have been changed. MSMS will monitor efforts to implement use of professional titles.

49-96A Title: Drive-thru Deliveries. Approved.

This resolution asked MSMS to actively support HB 5109 which requires health maintenance organizations to cover post-delivery, in-patient hospital services, for a mother and her newly born child for a minimum of 48 hours following a vaginal delivery and 96 hours following a cesarean section, unless mother and physician agree on an earlier discharge.

MSMS worked closely with Representative Sandy Hill to seek an appropriate conclusion with regard to this issue. As a result of the legislative process, the HMOs in the state of Michigan agreed to sign a document from the Insurance Bureau and the Department of Community Health stating that they would implement the American Academy of Pediatrics and American College of Obstetrics and Gynecology guidelines for post-partum maternity stay. The forms were sent out on July 19, 1996, and were signed and returned by every HMO in the state of Michigan.

In August, 1996, legislation passed at the federal level requiring health plans to cover at least 48 hours post-partum maternity stay for normal deliveries and cover at least 96 hours post-partum maternity stay for cesarian section deliveries. This new law will take effect January 1, 1998. In the meantime many questions have been raised regarding the enforcement of the contracts signed by Michigan HMOs stating that they would abide by American Academy of Pediatrics and American College of Obstetricians and Gynecologists perinatal standards. MSMS continues to work with other organizations to look into this matter.

50-96A Title: Illegal Practice of Medicine by Representatives of Third Party Payers. Adopted as Amended.

The resolution asked MSMS to request physicians to notify MSMS of incidents involving the practice of medicine by non-physicians employed by third party payers or by physicians in other states; and to pursue appropriate remedies.

No specific instances were brought to MSMS this year, although we will continue to monitor the issue. In the meantime, MSMS and specialty societies have been active in monitoring programs involving vendors from out of state. Physicians participate on several BCBSM advisory committess on programs involving radiology services and guidelines implementation and are active on similar committees for HMOs and PPOs locally and regionally. Efforts in these forums have included commenting on specific guidelines, monitoring information provided to physicians through vendors and examining approval rates for programs involving preauthorization. MSMS will continue to vigorously pursue the inclusion of Michigan physicians in these efforts, so that we can become immediately aware of any potentially illegal practices and pursue approriate remedies.

Title: Coverage of Immunization by Third Party Payers. 51-96A

This resolution seeks coverage of immunization by all insurers in Michigan and asks MSMS to work with employer groups to pursue coverage.

Blue Cross Blue Shield of Michigan this year introduced Community Blue, a new traditional program covering many previously uncovred services, including immunizations. This year, MSMS also began meetings with major health care purchasers, and have encouraged them to include immunization coverage. Finally, the MSMS Evaluation of Health Plans now reports immunization rates for health plans, hoping that public disclosure of this information will encourage plans to be more aggressive in seeking improvement in immunization rates.

52-96A Title: Medical Expert Witness. No Action.

53-96A Title: Designation of State and County Medical Society for Retired Physician Membership.



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This resolution asked MSMS to permit retired physicians to designate the county and state medical society where the physician last belonged for membership purposes regardless of the physician's address and that the AMA adopt the same policy. The resolution also asked the Michigan Delegation to the AMA to ask the AMA to permit retired physician members to designate the county and state medical societies where the physician last belonged as the tally and credit site for membership, regardless of the physician's retirement address.

MSMS current policy is that the retired physician be a member in the particular county in which he or she was a member while in practice regardless of their address once retired.

The Michigan Delegation introduced this resolution at the June, 1996, AMA House of Delegates, where it was adopted. The AMA already accredits the state where the retiree last paid dues for the membership tally. Delegates rejected the argument of a state where many physicians retire that it should be give the tally since that state provides the retirees with services.

54-96A Title: Senior Physicians Section. Disapproved.

55-96A Title: Snowmobile Speed Limit Legislation. Adopted as Amended.

This resolution asked MSMS to seek legislation which would allow any property damage or personal injury accident attributed to loss of control on a snowmobile trail to be prima-facia evidence of violation of the basic speed law. Also, that this legislation include a uniform basic speed law requiring snowmobiles not to go faster than trail conditions warrant or the applicable speed limit, whichever is slower, so as to protect those who maintain local trails while putting the responsibility for operation at a safe speed solely upon the snowmobile driver.

This resolution has been discussed within the context of several other public health concerns. MSMS strongly supports adequate safety standards when operating a snowmobile. MSMS supports legislation which would require standard enforcement of the Michigan seat belt law and strongly opposes attempts to repeal the Michigan helmet law. MSMS will continue to monitor these issues in addition to seeking legislation which would ensure adequate safety standards for operation of a snowmobile.

Title: Chemical or Biological Terrorist Attack in the United 56-96A States. Approved.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to identify the main risks of a terrorist chemical or biological attack against the US and to inform AMA members of proper emergency procedures and treatment in such an attack.

This resolution was adopted by the AMA at it's December, 1996, Interim meeting in Atlanta. The AMA will work with the appropriate governmental agencies to indentify the risks of terrorist chemical or biological attachs against the U.S. and inform members of proper procedure and treatment in such an attack.

57-96A Title: Establish an AMA-sponsored Network for International Medical Graduates. Approved.

This resolution asked the Michigan Delegation to the AMA to seek an AMA network for IMGs, to ask that the AMA establish criteria for network representation for IMGs in the AMA House of Delegates, provide adequate staffing and funding so that the network can function and serve as an advocate for IMG issues and concerns, and begin at once to assist the AMA IMG caucus in a transition to an IMG network.

The Michigan Delegation to the AMA introduced this resolution to the 1996 AMA Interim meeting in December where the AMA House approved the new AMA Section for International Medical Graduates (IMGs) members. The Section will meet for the first time at the 1997 AMA House of Delegates in June.

The Michigan Section has named Busharat Ahmad, MD, to serve on the AMA IMG Governing Council. The new Section will be charged with recruiting 1500 new AMA members in the next three years.

Title: Selection of Residents Based on Skill and Qualification. Adopted as Amended.

This resolution asked the Michigan Delegation to the AMA to reaffirm present policy providing for residency selection based on merit, skill and qualification irrespective of the school of graduation, to disseminate this policy widely to residency directors, to respond quickly and strongly to published or otherwise conveyed policies which discriminate against IMG selection for postgraduate



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medical training programs, and for the AMA to develop policies and procedures to monitor the selection of IMGs into postgraduate medical training programs.

The Michigan Delegation introduced this resolution at the June, 1996, Annual Meeting of the AMA House of Delegates, where it was adopted as amended. The resolution as amended reaffirms AMA policy that provides for residency selection on the basis of merit, skill and qualification. The delegates rejected the resolves calling on the AMA to monitor the selection process and to respond quickly to schools' policies, as they recognized that many factors enter into the process and "a balance must be achieved by the program director within the framework of basic principles."

59-96A Title: Restrict Access to Firearms for Children. No Action.

60-96A Title: Support Legislation Restricting Alcohol and Tobacco Advertising. Adopted as Amended.

This resolution asked that MSMS support legislation at the state and federal levels to ban alcohol and tobacco advertising on billboards or buildings within the immediate vicinity of schools and hospitals. Also, that MSMS support legislation at the state and federal levels to ban alcohol advertising during family and children television programs.

Legislation was introduced during the 1996 legislative session which would have effectively banned tobacco billboards altogether. In addition, MSMS worked with lawmakers to seek legislation that would have banned alcohol advertising within the immediate vicinity of schools and hospitals, however, the legislation did not pass by the end of the 1996 session. MSMS will work with lawmakers in the 1997 legislation session which will effectively implement House of Delegates Resolution 60-96A.

61-96A Title: Safeguarding Our Public Roads. No Action.

62-96A Title: Laser Surgery by Doctors of Medicine and Osteopathy. Referred to the Board for Study.

This resolution asked MSMS to actively support efforts in legislation that promote laser surgery on humans to be performed exclusively by licensed doctors of allopathic medicine, osteopathy, podiatry and dentistry with proper

The resolution was referred to the MSMS Board of Directors for study. which, in turn, referred the resolution to the Committee on State Legislation and Regulations. The Committee on State Legislation and Regulations met and discussed the resolution indepth and referred the resolution to the new MSMS Task Force on Scope of Practice issues for appropriate review. The MSMS Board of Directors recently reviewed the committee's recommendation for referral and stated that, in the meantime, MSMS should support legislation which recognizes the practice of laser surgery as surgery and should be treated by the law in such a serious manner. MSMS will work with the Michigan Ophthalmologic Society and other specialty societies to appropriately address this issue. The Scope of Practice Task Force is scheduled to review this at its April 2, 1997, meeting.

Title: Health Maintenance Organization (HMO) Contracts. Disapproved.

64-96A Title: Cost Effective Consolidation and Reorganization. Substitute Resolution (in lieu of 19-96A,64-96A and 81-96A). Adopted as Amended. See Resolution 19-96A.

65-96A Title: Determination of Disability and Impairment. Approved.

This resolution requested MSMS to encourage the appropriate agencies to adopt the AMA guidelines as standards for the determination of disability and impairment.

MSMS is working with the Office of the Governor to determine the most effective means of encouraging the appropriate agencies to adopt the AMA guidelines as standards for the determination of disability impairment. MSMS expects to be most effective with the administration's assistance.

66-96A Title: Domestic Violence. No Action.

67-96A Title: Physical and Mental Abuse. No Action.

Local Access

68-96A Title: Alternative to Physician Assisted Suicide. Adopted as Amended.

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This resolution asked MSMS to form a task force to study support and treatment options for chronically ill individuals who have considered as-

The MSMS End of Life Forums, beginning at the end of January, originally had been charged with studying support and treatment options of chronically ill individuals who have considered assisted suicide, as called for in this resolution. The Forums also were charged with studying circumstances under which assisted suicide might be the only alternative and what the safeguards or guidelines might be under those circumstances. The forum membership of about 20 outside organizations that have an interest in these issues realized that its focus must be more limited in order to accomplish anything in a timely manner. The forum membership, therefore, approved a motion to limit its debate as to whether or not various safeguards written into existing legislation in other states, in proposed model statutes and in the language of the Merian's Friends ballot initiative constituted a

The other portion of the intent of this resolution has been picked up by the MSMS Comittee on Bioethics. At its April meeting, the Committee discussed a motion supporting in whatever ways possible, the recommendations of the "Last Acts" Conference. That conference, established by the Robert Wood Johnson Foundation and attended by dozens of interested parties including the American Medical Association, made recommendations concerning all end of life care issues including advance directives, palliative care, spiritual care and hospice care. "Last Acts" also called for insurance coverage for these services and for an aggressive campaign to educate physicians and the public about these issues. The Bioethics Committee plans to establish a coalition to help support passage of any legislation in Michigan that may be needed concerning these issues.

Title: Stability of Health Insurance Coverage and the Doctor/Patient Relationship. Referred to the Board for Study.

This resolution asked that MSMS work with the health insurance industry to mandate three-year contracts for health insurance policies, and asked the Michigan delegation to make a similar request of the AMA. Although the issue intended to address the fact that patients may be forced to transfer from one plan to another when their employer changes the health plan that

it offers due to short term premium savings, thereby interrupting the physician-patient relationship, further exploration revealed that mandating multiple-year contracts may have unintended consequences for patients as well. A report outlining the issues was submitted in lieu of the resolution. The report was accepted by the Board of Directors at the March meeting and will be forwarded to the House of Delegates as an action report.

70-96A Title: Patient Satisfaction Surveys of Health Maintenance Organization (HMO) Mandated Laboratory and Radiological Services. Adopted as Amended.

This resolution asked that MSMS work with the Michigan Department of Community Health to develop standardized patient satisfaction surveys for managed care medical and/or clinical care, laboratory and radiology pro-

The Michigan Partners for Patient Advocacy seeks to expand upon the information made available to enrollees and other individuals who wish to have information about the health plan. The Michigan Partners for Patient Advocacy and MSMS intend to seek legislation and/or appropriate action to require health plans to share the results of patient satisfaction surveys. In order to accomplish this objective MSMS and the Michigan Partners for Patient Advocacy will work with the Michigan Department of Community Health and lawmakers in order to properly develop such surveys.

71-96A Title: Motorcycle Helmet Laws. Adopted as Amended.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to reaffirm current policy encouraging all state legislatures to make motorcycle helmet use mandatory in all 50 states.

This resolution was approved at the 1996 Interim Meeting in December and the AMA has reaffirmed already existing policy.

72-96A Title: Snowmobile and Boating DUI (Driving Under the Influence). No Action.

73-96A Title: Workers Compensation Current Procedural Terminology (CPT) Codes and Reimbursement. Adopted as



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This resolution asked MSMS to continue to support the utilization of current Procedural Terminology (CPT) by the Workers Compensation program and asked the Workers Compensation Advisory Committee to study whether the fee schedule should be adjusted to reflect the extensive correspondence cost, documentation requirements and physician services that are unique to the workers compensation system.

MSMS continues to support the utilization of Current Procedural Terminology (CPT) by the Workers Compensation program.

Currently, the Workers Compensation program is processes rules to change the Resource Based Relative Value Scale (RBRVS). They will be holding a workgroup to research how they will continue to update the workers compensation fee schedule. The MSMS Workers Compensation Task Force as well as the Workers Compensation Advisory Committee will continue to review on an ongoing basis whether the fee schedule should be adjusted to reflect the extensive correspondence cost, documentation requirements and physician services that are unique to the workers compensation system.

74-96A Title: Statewide Physician Owned and Directed Health Maintenance Organization (HMO) in Michigan. Substitute Board Action Report #10 (in lieu of 8-96A, 74-96A and Board Action Report #1). Adopted. See Board Action Report #10.

75-96A Title: Use of Appropriate Titles. Disapproved.

76-96A Title: Coverage for Today's Uninsured. Adopted as Amended.

This resolution asked the Michigan Delegation to the AMA to ask the AMA to study carefully the demographic characteristics of the uninsured and underinsured and to propose a rational set of recommendations for providing the uninsured and underinsured with health care coverage.

The Michigan Delegation introduced this resolution at the 1996 AMA Annual Meeting in June, where it passed verbatim. There was considerable testimony favoring the resolution, which coincides with the AMA's Health Access America policies. The resolution has been referred to the AMA Council on Medical Service for follow-up.

77-96A Title: Incentive Pay Detrimental to Physician/Patient Relationship. Disapproved.

78-96A Title: Medical Liability Tax. Disapproved.

79-96A Title: Direct Access to Specialty Care. No Action.

80-96A Title: Direct Access to Dermatologic Care. No Action.

81-96A Title: Distribution of American Medical Association (AMA) Delegates. Substitute Resolution (in lieu of 19-96A, 64-96A and 81-96A). Adopted. See Resolution 19-96A.

87-96A Title: Strategic Planning Task Force. Adopted as Amended.

The MSMS Standing Planning Committee met November 13, to update the MSMS Strategic Plan. The committee was expanded to include committee and section chairs in order to broaden the range of perspectives factored into the plan as prescirbed by a 1996 House of Delegates resolution.

The following were identified as key elements for the 1997 plan. Each is rated as an "A", "B" or "C" priority.

1. Membership - (A) - This is job number one. Without this, none of the rest of it matters.

2. Membership Among POs - (B) - Another membership focus is to increase MSMS membership among members of POs.

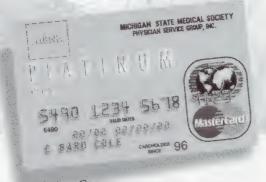
3. Membership Coordination - (A) - Coordinating membership efforts between the state and county organizations is a must. A successful effort will enhance membership at all levels.

4. Use MSMS: Don't Just Join - (A) - MSMS provides many services physicians could and should take advantage of. The more they do, the more they will value their membership and encourage others to join and participate.

5. Students and Residents - (A) - Working with students and residents is an ongoing agenda and is an important one.

6. Customize Communications - (B) - MSMS will provide customized communications that local societies can easily personalize with local material and distribute as a way of getting the word out more broadly.

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7. Osteopathy - (A) - MSMS will explore closer alignment with organized osteopathy as a way of stengthening the role of organized medicine in the state. This is a natural alliance that should be actively exercised to the benefit of both organizations.

8. Community Health - (A) - A key focus in 1997 will be an intensified community health presence through immunizations campaigns and similar

9. Managed Care Leadership Development - (A) - Importance: B/C -Feasibility) - MSMS can help physicians learn the skills necessary for managed care leadership and position themselves for this new challenge.

10. Quality Control - (C - Importance; A - Feasibility) - The most important product for MSMS is service to physicians, and in 1997, MSMS will pay special attention to assessing and exploring ways to improve the quality

11. Section for Medical Directors - (A) - This is becoming a large enough group to consitute a sufficient critical mass to warrant its own forum for discussion of issues of unique and special interest.

12. Uniformity of Managed Care Guidelines - (A+) - The growth of managed care has been accompanied by the establishment of guidelines and standards for care within each system and large group.

13. Collaboration with Managed Care on Public Health - (A) - One of the opportunities to build bridges with the managed care community is on public health issues such as tobacco, immunizations, alcohol abuse, etc.

83-96A Title: Single Payer Health Plan. Disapproved.

84-96A Title: Brand Drugs vs. Generic Drugs. Disapproved.

Title: Support Senate Bill 1028 to Prohibit Insurance Com-85-96A panies From Using the Pre-Existing Clause. No Action.

Title: Parity for Mental Illness. Adopted as Amended.

This resolution asked MSMS to support legislation that covers the treatment of mental illnesses to the same limits applied to the treatment of all other non-psychiatric diagnoses. The resolution also asks MSMS to support legislation that gives the treatment of mental illness the same scope and

duration of coverage and be subjected to the same reviews, severity, standards and effectiveness requirements as treatment for other medical illnesses.

MSMS has worked closely with Representative Liz Brater, D-Ann Arbor, to support House Bills 4911-4913, which would create parity and insurance for mental illness. In the meantime legislation passed at the federal level to require, to a limited degree, health plans to cover mental illness as they would cover physical illness. The impact of the federal legislation is still to be reviewed, however, initial studies indicate that state legislation will be necessary in 1997 and MSMS will continue to support that legisla-

87-96A Title: Care for Children and Adolescents with Emotional Disorders. Approved.

This resolution asked MSMS to study the problem of the care and treatment of children and adolescents with emotional disorders, give recommendations for remedy, and propose legislation or changes in public policy.

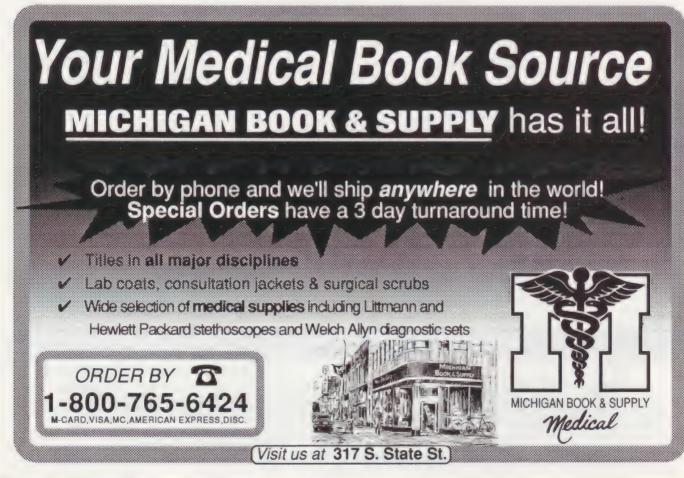
MSMS continues to work closely with the Michigan Department of Community Health's Mental Health Agency to provide recommendations for easier access and treatment of children and adolescents with emotional dis-

88-96A Title: Prostate Cancer Control Plan for Michigan. Referred to the Board for Study.

This resolution requested MSMS to endorse the goals of the Michigan Cancer Consortium and help support the professional education component of the Prostate Cancer Control Plan for Michigan.

MSMS participated in the development of the Michigan Prostate Cancer Consensus Conference and believes that the objective of this resolution has been accomplished. MSMS has offered the Michigan Prostate Cancer Consensus Conference statements and recommendations for further study to its members through Medigram. MSMS will continue to work with the appropriate agencies and organizations to address this and other important cancer related issues.

89-96A Title: Prohibition of Ultimate Fighting (Barbaric and Blood Sports). Adopted as Amended.



This resolution asked MSMS to oppose ultimate fighting (barbaric and blood sports) competitions in the state of Michigan and that MSMS seek legislation to prohibit ultimate fighting and ban its transmission via electronic media.

MSMS supported legislation that was signed into law during 1996 which bans ultimate fighting of barbaric and blood sports from taking place in the state of Michigan.

90-96A Title: Interruption of Chronic Care Received by Paroled Prison Inmates. Disapproved.

91-96A Title: Create Identical Health Care Bill Form. Approved. This resolution asked MSMS to seek legislation mandating that all health insurance companies and managed health care companies in Michigan use

an identical billing form.

During 1996, MSMS has strongly supported HB 4903-4907, which would require health plans to utilize universal claims standards. The MSMS Subcommittee on Universal Claims Standards met with the House Insurance Committee Subcommittee on Universal Claims Standards to urge them to support HB 4903-4907. In addition, the bills were amended to include the specific recommendations of MSMS. Several hearings took place regarding this matter and discussions among various interest groups also took place. Although legislation is not expected to pass this session, it is our understanding that the bills will be reintroduced next session by Representative Sandy Hill when she expects to move the legislation forward.

92-96A Title: Proposed Changes in the Omnibus Budget Reconciliation Act (OBRA), Health Care Financing Administration (HCFA) Regulations and Michigan Department of Public Health (MDPH) Rules Requiring Therapeutic Interventions for Nursing Home Patients. Adopted as Amended.

The resolution asked MSMS to recommend to the Michigan Department of Consumer and Industry Services that regulations regarding therapeutic interventions for nursing home patients be written to accommodate patient and family choice for treatment of an individual on a case-by-case

The MSMS Committee on Aging exchanged correspondence, met with the original author of this resolution and made recommendations regarding this matter to the physician prior to the matter becoming the subject of this resolution. During the September 25, 1996, meeting of the Committee on Aging, Resolution 92-96A, especially the resolved portion, was the subject of Committee discussion. There was a review of the various rules, regulations and guidelines pertaining to patients rights as published in the Long Term Care Facility Guidelines used by the Michigan Department of Community Health during facility surveys. The Committee determined after a review of the National Nursing Home Reform Act Regulations which are a part of OBRA's '87 law, that minimally five regulations, 20201(2)(d)-(2e), 20201 (2)(d)-(2f), 20201 (2)(d)-(2h), 20201(3)(c)(d), and 20201 (2)(m), are in existence which pertain to the resolved portion of the resolution and therefore, the resolution has been addressed by the appropriate agencies.

93-96A Title: Pursue Changes in Michigan Public Health Code Regarding No-Codes. No Action.

94-96A Title: Consistency in Drug Formularies. Disapproved.

95-96A Title: Standardize Insurance for Physician Participation Rules. Adopted as Amended.

The resolved portion of this resolution requested that MSMS seek legislation that would require all managed care companies and health insurance companies to have identical rules for physician credentialing and privileges by insurance type.

MSMS was a major participant in the passage of the Michigan Patient Bill of Rights. Although the subject of the resolved portion of this resolution was a matter receiving considerable testimony from MSMS, Michigan physicians and representatives from managed care organizations, the final form of the Michigan Patient Bill of Rights did not contain language addressing this resolved.

MSMS Department of Physician Hospital Relations has been working with the Medical Directors Committee of the Michigan Managed Care Organizations to develop a common credentialing application for the 22 managed care organizations in Michigan.



96-96A Title: Discrimination by Health Insurance Carriers Against Breast Reconstruction. Adopted as Amended.

This resolution requested MSMS to work with health insurers to encourage coverage for breast reconstruction following breast cancer surgery, and to encourage coverage of costs associated with all stages of breast reconstruction.

MSMS found that exclusion of these services is often due to exclusions and definitions of elective surgery; and due to decisions of employer purchasers. MSMS will include discussion of this issue in our new dialogue with employers, and is taking steps to ease the process of individual consideration by insurers of whether to pay for these services. This will be an ongoing effort.

97-96A Title: Full Michigan Licensing for Out-of-State Physicians Who Provide Medical Services to Michigan Residents via Telemedicine Services. Referred to the Board for Study.

This resolution asked MSMS to support the requirement of full Michigan medical licensure for non-resident physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients within Michigan, and that MSMS seek legislation requiring full Michigan medical licensure for non-resident physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients within Michigan.

Please refer to Resolution 28-96A

98-96A Title: Hospital Medical Staff Credentialing of Physicians Who Provide Electronic and Other Telemedicine Services for Hospital Patients. Referred to the Board for Study.

This resolution asked MSMS to support the requirement of physicians who provide diagnostic or therapeutic services on a regular, ongoing or contractual basis via electronic or other communications to patients in a hospital setting within Michigan to be fully credentialed by that hospital's medical staff in accordance with the medical staff bylaws, and that MSMS support the requirement of physicians who provide diagnostic therapeutic services on a regular, ongoing or contractual basis to patients in a hospital setting within Michigan solely via electronic or other distant communications (and so would not otherwise ever have any direct personal interaction with the remainder of the medical staff) be credentialed as active members of that hospital's medical staff and be held to the same standards of requisite responsibilities as other active members of the medical staff.

Please Refer to Resolution #28-96A

99-96A Title: Create Scope of Practice Board. Disapproved.

100-96A Title: No Cardio Pulmonary Resuscitation (CPR) Orders in Adult Foster Care and Assisted Living Settings. Not Accepted as a Late Resolution.

101-96A Title: L-glutamic Acid. Not Accepted as a Late Resolution.

102-96A Title: Equal Medicare Payments to Rural Health Clinics. Not Accepted as a Late Resolution.

103-96A Title: Preventing and Remedying Lead Poisoning in Michigan. Approved

This resolution asked MSMS to support the adoption and implementation of a statewide blood-lead report and tracking system, to support the pursuit by the state of Michigan of federal funding, support the allocation of state environmental cleanup funds and to support a partnership of all state and local public health agencies, and physicians to prevent lead poisoning through education.

The State of Michigan has agreed to receive available federal funds to assure lead abatement programs are conducted in order to reduce public health risks. It is our understanding that lead abatement programs, while not running at full capacity, are currently in effect throughout the state. MSMS will continue to monitor these programs through the MSMS Liaison Committee for Michigan Public Health and promote these programs through Medigram and Michigan Medicine.

Title: Physician Delegation of Controlled Substances to Physician Assistants. Not Accepted as a Late Resolution.

105-96A Title: Providing for the Care of Persons With Mental Illness. Not Accepted as a Late Resolution.

106-96A Title: Certificate of Need (CON) Reform. Approved.

This resolution asked MSMS to endorse the efforts of members who seek an injunction against the retroactive effect of the January, 1996, Certificate of Need (CON) rules.

MSMS will endorse efforts by members who seek an injunction against the retroactive effect of the January, 1996, Certificate of Need (CON) rules.



Delegates' record of attendance May 2-4, 1997

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OFFICERS: Speaker:	1st	2nd	3rd	GRATIOT: Ashok R. Sonnad, MD	X	X	Х
Dorothy M. Kahkonen, MD	X	X	X	HILLSDALE: Michael J. Parks, MD	X	X	Х
Vice-Speaker: Paul O. Farr, MD	X	X	X	HOUGHTON-BARAGA-KEWEENAW: Rudy W. Stefancik, MD	X	X	X
Secretary: Thomas R. Berglund, MD	Х	Χ	X	HURON: Helen J. Scoblic, MD			
DELEGATES AND ALTERNATES ALLEGAN: Not Represented				James Greenfield, DO INGHAM:	X	X	X
ALPENA-ALCONA-PRESQUE-ISLE: Richard D. Bates, MD Peter Aliferis, MD	X	X		Glen N. Ackerman, MD Don G. Davis, MD Julie A. Dodds, MD Omero S. Iung, MD	X X X	X X X	X X X X X
BARRY: David M. Woodliff, MD	X	X	X	David K. Johnson, MD Edward D. Lanigan, MD Brian R. McCardel, MD	X X X	X X X	
BAY: Scott A. Baker, MD	Х		X	Mohammad Mohsenian, MD Mitchell A. Rinek, MD Phillip B. Storm, MD	x	X	X X
Mark C. Komorowski, MD		į			,	Λ	Λ
Bernhardt L. Pederson, MD Carol L. van der Harst, MD	X	X	X X	IONIA-MONTCALM: Doyle E. Calley, MD	X	Χ	X
BERRIEN: Fred M. Busse, MD	Х	X	X	IOSCO-ARENAC: Surya N. Sankaran, MD	X	X	X
Thomas D. Huntington, MD Linda K. Stanley, MD	X	X	X	ISABELLA-CLARE:			
Dennis C. Szymanski, MD	X	X	X	Not Represented			
BRANCH: Jeffrey C. Custer, MD				JACKSON: Richard M. Byler, MD	Х	X	Х
CALHOUN:				Moses Muzquiz, MD Bernard Z. Reizner, MD	X X	x	X
Jeffrey R. Mitchell, MD Røbert W. Oakes, MD	X	x	X	KALAMAZOO:			
Stephen L. Smiley, MD	X	X	X	Donald H. Batts, MD	X	X	X
Dale L. Syverson, MD	X	X	X	Owen M. Berow, MD Thomas M. George, MD	X X X	X	X
CASS: Boonchoo Chang, MD			,	Joseph E. Kincaid, MD David A. Milko, MD	X X	X X X X	X X X X X X
Donello Chang, MD				Dale E. Rowe, MD			X
CHIPPEWA-MACKINAW:				John R. Trittschuh, MD Ronald L. VanderLugt, MD	X X	X	X
Edward N. Johnson, MD	X	X	X	Geoffrey A. Wardwell, MD Janice L. Werbinski, MD	X	X	x
CLINTON: Donald L. Porter, MD		•	,	William H. Woodhams, MD Robert E. Rensch, MD B. David Wilson, MD	X X X	X	X
DELTA: Carol A. Krieg, MD	Х	X	X	KENT:			
DICKINSON-IRON:				John H. Beernink, MD R. Paul Clodfelder, MD	X X	X	X X X
Not Represented				Michelle M. Condon, MD Patrick J. Droste, MD	X	X	X
EATON:				Douglas A. Edema, MD			-
Kory V. Deason, MD	X	X	X	Paul O. Farr, MD Domenic R. Federico, MD	X	X	X X
GENESEE: Ali A. Esfahani, MD				Gregory J. Forzley, MD Karyn E. Gell, MD	X	-	X X X
Cyrus Farrehi, MD				John H. Kopchick, MD	X	X	
George H. Greidinger, MD Edwin H. Gullekson, MD	X	X	X	Ann M. Minnema, MD John P. Papp, MD			
Vivian M. Lewis, MD Sudarsan Misra, MD	X	X	X	Sarla Puri, MD Robert C. Richard, MD	X	X	X
AppaRao Mukkamala, MD	X	X	X	Jack L. Romence, MD	X	X X	X X
W. Archibald Piper, MD Jagdish K. Shah, MD		x	X	Paul G. Schutt, MD	X	X	X
Robert M. Soderstrom, MD Allen F. Turcke, MD	X	X	X	Anthony J. Senagore, MD David L. Sharp, MD			
Virgilio Villarreal, MD	-		-	Kathleen J. Yost, MD	X	X	X
Adb A. Alghanem, MD Amitabha Banerjee, MD	X	X	X	David P. Hejna, MD John R. Houskamp, MD	X	x	X X
Michael C. Boucree, MD Pino Colone, MD	X	X	X	Richard A. Ilka, MD Michael D. Olgren, MD	X	x	X
Kenneth A. Jordan, MD	X	X	X	Bruce C. Springer, MD	X	X	
Venkat K. Rao, MD	Χ	X	X	Angela R. Tiberio, MD Ronald L. Vanderlaan, MD		X	X X
GOGEBIC: Not Represented				David A. VanderWall, MD David D. Verdier, MD	X X	X X X	X
GRAND TRAVERSE-LEELANAU-BENZIE:			v	LAPEER:			
David B. Martin, MD Edward J. Rutkowski, MD	X	X	X	D. V. Ramana, MD	,		1
Richard C. Schultz, MD Peter Sneed, MD	X	X	X	LENAWEE: Inad Haddad, MD	X	X	X

			•	Barry Siegel, MD Ghalib Y. Talia, MD			
.IVINGSTON: Chomas F. Higby, MD	Х		X	Bharat M. Tolia, MD Sherry L. Viola, MD			
· · ·	A		A	Gertraud Wollschlaeger, MD		-	
.UCE: Not Represented				Benedicto C. Cortez, MD Renato L. Raymundo, MD	X	X	
AACOMB:				OCEANA:			
Adrian J. Christie, MD	*	-		Steven R. Lessens, MD			
awrence F. Handler, MD Paul R. Kipp, MD	x	x	X	ONTONAGON:			
Robert R. Peleman, MD	Α,	Α.	Α	Steven N. Gervae, MD			
Richard H. Schiappacasse, MD	X	X	X				
Milton F. Simmons, MD Akemi Takekoshi, MD	X	X	X	OTTAWA: William D. Doebler, MD			
Michael E. Tofteland, MD		-		M. Gary Robertson, MD	X	X	
Renato A. Villanueva, MD Bruce E. Carl, MD	x	x	X	Donald E. Sikkema, MD			
Peter V. Kane, MD	^	^	X	SAGINAW:			
Assad A. Mazhari, MD	X	X		Waheed Akbar, MD			
Kathryn H. Sussman, MD Richard V. Utarnachitt, MD	X X	X	X	Edward P. Balcueva, MD Richard P. Heuschele, MD	X	X	
	**			Stephen A. Morris, MD	X		
MANISTEE: Vickers C. Hansen, MD	X	X	X	Charles E. Mueller, MD Jacob C. Ninan, MD	X	X	
ickets C. Hansen, IVID	A	Λ	^	Conchita D. Riparip, MD	x	X	
MARQUETTE-ALGER:				Caroline G. M. Scott, MD	X	X	
Cheryl Davison, MD Carl F. Hammerstrom, MD	X X	X	X	Bala Srinivasan, MD		X	
Allan Olsen, DO	X	X	X	ST. CLAIR:			
MASON:				Timothy B. Aiken, MD Jere F. Baldwin, MD	x	X	
Not Represented				S. G. Muthusawami, MD	X	X	
				Edward J. Nebel, MD	,	-	
MECOSTA-OSCEOLA-LAKE: David C. Nolan, MD		,		ST. JOSEPH:			
				Douglas L. Colberg, MD		X	
MENOMINEE: Not Represented				SANILAC:			
tot represented				Sosale M. Berkuchel, MD	X		
MIDLAND:	V	V	V	CCUOOL CRAFT			
mothy J. Kosinski, MD avid E. Randolph, MD	X	X	X	SCHOOLCRAFT: Not Represented			
nomas J. Zuber, MD	X	X	X				
ONROE:				SHIAWASSEE: Timothy D. Oliver, MD	X	Χ	
enneth J. McNamee, MD		X	X	Innotity D. Oliver, MD	Λ	Λ	
. R. Nair, MD	X	X	X	TUSCOLA:			
Busharat Ahmad, MD	X	,	•	Afonso C. Ferreira, MD	X	X	
MUSKEGON:				VAN BUREN:			
rederick B. Brown, MD tephen E. Fisher, MD	X X	X	X	George A. MacDonald, MD		*	
Pavid Nadeau, MD	X	X	X	WASHTENAW:			
obert C. Packer, MD	X	X		Tama D. Abel, MD	X	X	
IEWAYGO:				Lynn W. Blunt, MD Robert R. Bree, MD	X	-	
ames D. Webb, MD	X	X	X	Allan C. D. Brown, MD	X	X	
ORTH CENTRAL:				Mary B. Durfee, MD Carl M. Frye, MD	*	-	
Villiam H. McNamara, MD	X	X	X	David W. Learned, MD		-	
CRYLLERAL MICHIGAN				Manfred Marcus, MD	X	X	
ORTHERN MICHIGAN: ruce G. Deckinga, MD	Х	X	Х	Michael A. Masini, MD John M. O'Brien, MD			
Charles J. Heyka, MD	X	X	X	Diana M. Rothman, MD		-	
	X	X	X	Michael W. Smith, MD Carl Van Appledorn, MD	X	X	
ouis R. Zako, MD	7.						
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AKLAND: ime V. Aragones, MD	х	X	X	Scott W. Woods, MD Steven C. Harwood, MD	X X	X X	
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filliam A. Harrity, MD						
lelvin L. Hollowell, MD						
	X	X	MI CHAPTER - AMERICAN COLLEGE OF EMERGENCY PHYSICIA Gregory L. Walker, MD	XX	Х	
ichael Iacobellis, MD		-				
nn-Mare Ice, MD	X	X	MI ACADEMY OF FAMILY PHYSICIANS:			
amuel D. Indenbaum, MD	X	X	Michael G. Workings, MD		-	
cha Janviriya, MD						
nes E. Kackley, MD		-	MI SOCIETY OF GASTROINTESTINAL ENDOSCOPY:			
orothy M. Kahkonen, MD	X	X	Not Represented			
orge M. Kazzi, MD	-	-	MI SOCIETY OF GENERAL SURGEONS:			
nder P. Klein, MD Michael Krieg, MD		-	Donald C. Camp, MD	X	X	
enry R. Kroll, MD		-	Bollaid C. Callip, MD	Λ.	Λ.	
obert P. Lilly, MD		X	MI SOCIETY OF INFECTIOUS DISEASE:			
chard Menczer, MD		-	H. Gunner Deery, II, MD			
amran S. Moghissi, MD	X	X	an outside body, any was			
vin M. O'Brien, MD		-	MI SOCIETY OF INTERNAL MEDICINE:			
seph R. Oldford, MD			Richard H. Wakulat, MD	X	X	
ussel F. Proud, MD						
oster K. Redding, MD	-	-	MI ASSOCIATION OF MEDICAL EXAMINERS:			
n Rival, MD	*		Reed K. Freidinger, MD	X	X	
ichael A. Sandler, MD	X	X				
zabeth L. Schmitt, MD		-	MI ASSOCIATION OF NEUROLOGICAL SURGEONS:			
anklyn E. Seabrooks, MD	*	-	Steven E. Newman, MD	X	X	
ed R. Severyn, MD	*	X				
rinder K. Sherma, MD	•	-	MI NEUROLOGICAL ASSOCIATION:			
eborah W. Sims, MD	-	-	Steven E. Newman, MD	X	X	
lando S. Sison, MD	-	-	AU COLLEGE OF MICHEAR A (PROCESSE AVERAGE)			
mar K. Sonbay, MD	v	-	MI COLLEGE OF NUCLEAR MEDICINE PHYSICIANS:			
thur A. Ulmer, MD	X	*	Not Represented			
v Victor, MD ed W. Whitehouse, MD X	x	v	MI SECTION - AMERICAN COLLEGE OF OBSTETRICS AND GYN	ECOLOGI	v.	
		X	Domenic R. Federico, MD	X	Y: X	
rnard J. Woodley, MD mir R. Yahia, MD		-	Domenic R. rederico, MD	Λ	Λ	
Kwang Yoon, MD			MI OCCUPATIONAL AND ENVIRONMENTAL MEDICAL ASSOCI	ATION.		
Deloris A. Berrien-Jones, MD X	x	X	Not Represented	II II IOIN.		
Michael Brennan, MD	X	^	. to aprovince			
Matthew L. Burman, MD X	X	X	MI OPHTHALMOLOGICAL SOCIETY:			
Benjamin Chaska, MD X	X	X	Jeffrey A. Diskin, MD	X	X	
Frederick W. Fitzpatrick, MD X	X	X				
J. Alan Robertson, MD X	X	X	MI ORTHOPAEDIC SOCIETY:			
			Kenneth S. Merriman, MD	X	X	
EXFORD-MISSAUKEE:						
ot Represented			MI OTO-LARYNGOLOGICAL SOCIETY:			
			Michael J. LaRouere, MD		-	
			A COOLEMA OF BARRIAGE OF STATE			
ELEGATES-AT-LARGE			MI SOCIETY OF PATHOLOGISTS:		V	
DOLL CHIEF MEDICAL OFFICER			William A. Springstead, MD		X	
DCH CHIEF MEDICAL OFFICER: avid R. Johnson, MD, MPH X	X	X	MI CHARTER AMERICANI ACADEMY OF REDIATRICS			
	Α	Α.	MI CHAPTER - AMERICAN ACADEMY OF PEDIATRICS:	37	27	
EMPERCATIANCE						
EMBERS-AT-LARGE			Irving M. Miller, MD	X	Х	
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MMEDIATE PAST PRESIDENT:	X	X	MI SECTION OF CLINICAL PHARMACOLOGY & THERATPEUTIC		Х	
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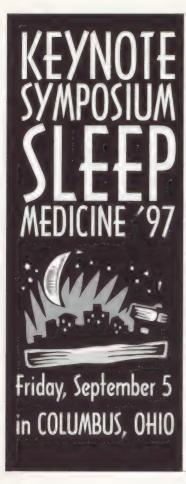
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One photo...



Delegates to the 1997 MSMS House of Delegates meeting May 2-4 in Traverse City found hallway conferences helpful in gathering background on the issues. Intensely involved in conversation, above from left, are Greg Messenger, MD, Lansing, who came to testify on a resolution, and Delegates Mitchell S. Rinek, MD, Lansing, and Steven E. Newman, MD, Southfield.





November 5, 6 & 7, 1997 • The Hyatt Regency, Dearborn

Wednesday Morning, November 5, 1997 8:30 a.m. to noon with a half-hour break.

Basic Cardiac Life Support Dermatological Use of Lasers

Brain Attack

Pediatrics: Pearls and Pitfalls Radiology for Clinicians

Designing Business Strategies that Work for You*

The Customer-Oriented Medical Practice-Part I*

Wednesday Afternoon, November 5, 1997

1:30 p.m. to 5:00 p.m. with a half-hour break.
Basic Cardiac Life Support

Pain Management and End of Life Care Frequently Encountered Neurological Problems

Quality Improvement in Cardiovascular Care

Obesity Management

Peer Review-New Dimensions and New Importance

The Customer- Oriented Medical Practice-Part II*

*These courses will be conducted for office managers and staff members. They will not receive CME credit.

Thursday Morning, November 6, 1997

"Early Bird" Plenary Session, 7:15 a.m.-8:15 a.m. Cancer Screening and Prevention in Primary Care

8:30 a.m. to noon with a half-hour break.

Basic Cardiac Life Support

Allergic Rhinitis and Latex Allergy

Review of Breast Cancer Treatment

Recognition and Treatment of Common

Athletic Orthopaedic Injuries in Children

Guidelines in the Treatment of Prostate

Mergers and Consolidations*

A Physician's Guide to Evaluation and Management Coding and Documentation*

Thursday Afternoon, November 6, 1997

1:30 p.m. to 5:00 p.m. with a half-hour break.

Management of Chronic Pain in Theory
and in Practice

The Spectrum of Anaphylaxis

Nuances of Breast Reconstruction

Orthopaedic-Sports Medicine Approach to Occupational Injuries

Saving the Diabetic Foot

Breast Cancer Diagnosis: Medical and Legal Risk Management Principles

Regulations in the Physician's Office:

Who's Looking Over Your Shoulder?*

Friday Morning, November 7, 1997

"Early Bird" Plenary Session, 7:15 a.m.-8:15 a.m. Gene Therapy

8:30 a.m. to noon with a half-hour break.

Hypertension

What's New with the Nose?

Risks and Benefits of Menopausal Hormone

Replacement Therapy

Save 100: Intro to Quality, Cost-Effective

Prescribing

Technology-Symposium

Friday Afternoon, November 7, 1997

1:30 p.m. to 5:00 p.m. with a half-hour break. Immunizations for a Lifetime Colon and Rectal Surgery

Addressing Sexual Difficulty, Distress and Dysfunction in Primary Care Practice

Food and Chronic Illness Technology-Symposium



This conference is co-sponsored by Michigan State Medical Society and Blue Cross Blue Shield of Michigan.

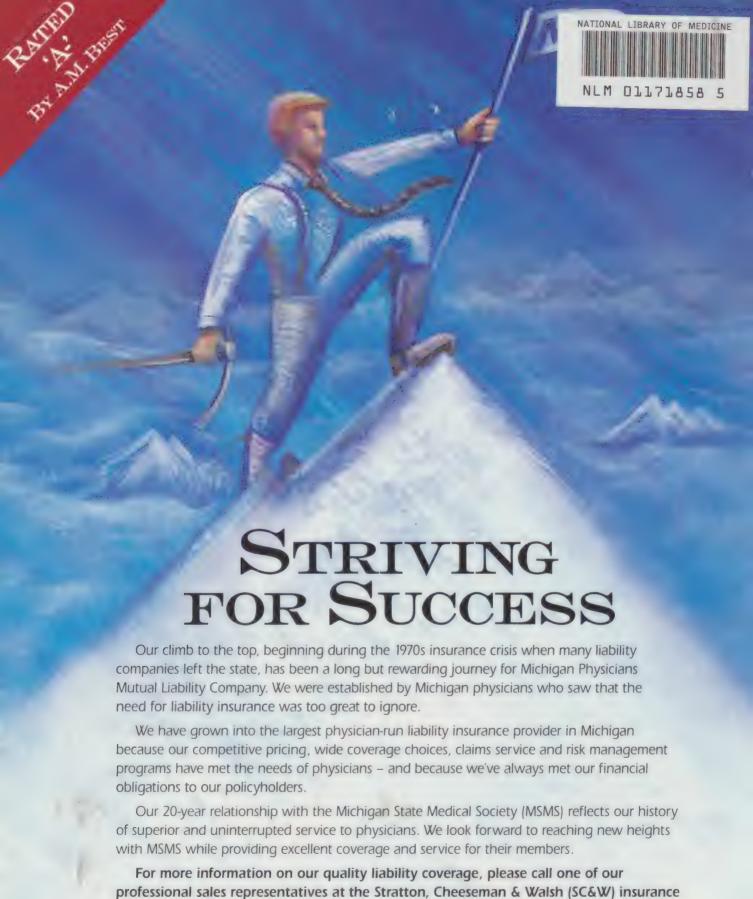
A complete list of courses and a registration form will be published in a Medigram "Special Issue" in August.

For more information, or to request a registration form, call Brenda Eberly at (517) 336-5784.

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The MSMS Committee on CME Programming, an organization accredited by the MSMS Committee on CME Accreditation, designates this activity meets the criteria for a maximum of 20 hours of Category I Credit toward the requirements for Michigan relicensure and of the Physician Recognition Award of the AMA, provided it is completed as designed.

Each concurrent course offers 3 hours of Category I CME credit. The plenary sessions on Thursday and Friday mornings offer 1 hour each of Category I CME credit.



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MichiganMedicine

COVER STORY



Telemedicine: Who's in Charge?

10

The field of telemedicine has evolved to include exciting applications that improve access, reduce costs and enhance care. Advanced technologies—such as high-resolution digital video, codes that convert video and audio signals to digital and back, fiber optic cable and computerized workstations stocked with a wide array of scopes and diagnostic instruments—are already reality for some physicians. Yet, the aweinspiring capabilities of technology are wrought with worrisome implications. By Karen Bouffard

Cover photographs courtesy of Siemens Medical Systems, Inc. Graphic Chart of future imaging department courtesy of Sterling® Diagnostic Imaging.

FEATURES

PHYSICIAN PROFILES

Jack Stack, MD Cassandra Klyman, MD

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Small-town physician earns fame and respect both in the mid-Michigan area and throughout the state. The new chair of the MSMS Committee on Concerns of Women Physicians brings unique insights to the health needs of women—both their mental and spiritual health. By Ralph D. Ward

VIEWPOINT

Nurses' Claims Unsubstantiated

A Michigan doctor disputes the theory of lowering health care costs with prescriptive privileging for APNsand discusses the problems surrounding this issue. By Tom M. George, MD

LEGISLATIVE PROFILE **Better Health Care Legislation**

State Senator Dianne Byrum details recent "wins" in health care legislation, and discusses her new health care package.

By Kristen M. Lare

LEGISLATIVE PROFILE

Medicare Preservation

28

The House of Representatives Committee on Ways and Means recently preserved Medicare while giving senior citizens more choices for their health care coverage.

By U.S. Congressman Dave Camp

September 1997 Volume 96, Number 9

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MSMS E-mail Address: msms@msms.org



FEATURES

RISK MANAGEMENT

Strategies for Your Practice

This fall 1997 seminar series offers valuable resources to meet practice and business challenges. Three seminars will address current topics in regulatory compliance, reimbursement, capitation and quality improvement.

By Mary Anne Ford

PRACTICE MANAGEMENT

Women in Medicine

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September is "Women in Medicine" month, and MSMS gives a snapshot view of female MSMS members. By Julie L. Lester

PRACTICE MANAGEMENT

Michigan Takes a Shot at Immunization Registry

50

September 30, 1997, is the target date to have all six regions across Michigan activated under the new Michigan Childhood Immunization Registry.

By Mary E. S. Jensen

SPECIAL FEATURE

MSMS Board Looks at Tough Questions to Plan Future

52

During the Midsummer Board Meeting, strategic planner Michael G. Skinner, PhD, presented an intense seminar that addressed many questions and concerns of organizations today.

By David K. Fox

What do you think? Return the fax-back survey form on page 54.

MSMS ALLIANCE

Physicians Plus Spouses Equal a Parnership for Better Health

Newly elected Alliance President, Blanche Mindlin reflects on recent Alliance victories, and highlights her goals for the next year.

By Blanche L. Mindlin

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Look for Michigan Medicine On-line at http://www.msms.org/

Question:

Would you encourage your child to enter the field of medicine?

Yes. It has provided me with a really satisfying career, the opportunity to help my fellow human beings. Through my colleagues, I have had the opportunity to associate with some of

the finest minds and best personalities on this planet.

D. Moore Hislop, MD

Obstetrics and Gynecology, Port Huron

Yes. In spite of the state of flux that society is in with regards to medical care delivery, the need for caring, committed individuals will always be a priority.

Douglas A. Mack, MD

Public Health, Grand Rapids

Yes. If he or she is clearly interested in working hard, can function well with little sleep and under intense pressure and, most important, if he or she wants to help others.

David R. Johnson, MD, MPH

Public Health, Lansing

No. After going through an immense amount of time to get the necessary education and training to become a physician, along with a tremendous amount of money spent, and the level of discomfort and constraint that is put on a physician's life, the end product is not worth the effort. It is not fun anymore in any way to practice medicine.

Kalyani Misra, MD, MPH Public Health, Grand Blanc After tremendous discussion regarding the positive and negative aspects of today's medical practice, I would persist that medicine is still the greatest profession. There

should, of course, be not only a calling and enthusiasm, but also the zealousness to confront present-day problems associated with a medical practice.

J.M. Kobiljak, MD

Pediatrics, Warren

Most definitely, given that there was an interest in a career in medicine. I have three different children with interests ranging from pure sports (a "jock" in my house?), to an electrical/gadget wizard, to an artist and a dancer. Each would contribute greatly, yet uniquely to the field of medicine using their innate interests and talents. Medicine presents more opportunities to use their diverse interests now than ever before. I see the opportunities only growing as the scope and depth of medical expertise continue to grow exponentially. There is no question that I would support even a spark of interest on their part – medicine remains a field of huge personal satisfaction and reward; to be able to help another human being to remain healthy or accept a disease they did not ask for; to live a life of daily reward and to have a career that makes them want to go to the office or wherever, it takes them to promote well-being in the community in which they live.

Greg Forzley, MD

Family Practice, Grand Rapids

BACKTALK is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to *Michigan Medicine*, Backtalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490, or e-mail them to jmarr@msms.org/

Errata

In the July, 1997 issue (Vol. 96, No. 7) of Michigan Medicine, in the "Special Membership" section (p.44), Ara Yarjanian, MD was misspelled.

In the July, 1997 issue (Vol. 96, No. 7) of Michigan Medicine, in the classified ads section (p.71), the word "physician" was misspelled under the "expert witness" classified ad.

The staff of Michigan Medicine and MSMS apologize for these errors, and have made sure that our records are updated and correct.

Executive Director William E. Madigan

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Grand Rapids

Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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Golf Classic earns \$20,000 for Health Education Foundation Projects

Photos by Kurt McKellar, Lansing

Mark your calendar! The 1998 MSMS Foundation Golf Classic is May 18 at the Country Club of Lansing.

On a windy May 19, the MSMS Health Education Foundation (HEF) hosted 154 Michigan physician golfers and their friends, who raised \$20,000 to benefit the physicians selected charitable organizations. The 5th annual HEF Golf Classic, held at the Country Club of Lansing, boosted the Foundation's capabilities to endow community health improvement projects across the state.



On the driving range at the start of the outing are, from left, Edward J. Rutkowski, MD, Traverse City; Donald B, Muenk, MD, Warren and MSMS President Peter A. Duhamel, MD, Rochester Hills.



Foundation President Robert E. Paxton, MD, gave golfers their instructions as the tournament began.



One happy foursome included, from left, Willard S. Stawski, MD, Grand Rapids; David Share, MD, Ypsilanti; Eldon Warr Sr.; John J. Coury, MD, Port Huron.



The MSMS Alliance foursome included, from left, Past President Bev Jensen, Grand Rapids; President-elect Lila Esfahani, Detroit, and President Janet Gregory, Traverse City. Also on the team was Barb Grennan, Muskegon.

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Self Referral Law: Court's Interpretation Intolerable

By Richard D. Weber, JD

MSMS Legal Counsel



Question: Our physician organization is planning to create an ambulatory surgical center in conjunction with other physician organizations and the local hospital. The individual physicians and the hospital will be investors. We intend to refer our patients to the facility. This will be more convenient to our patients and the physicians, and less costly than hospitalizing the patient for the procedure. We realize that this arrangement is acceptable under federal law, but Michigan law may preclude investor physicians from referring their patients to this facility. Please explain this law and what MSMS is doing about it.

Answer:

The Michigan Public Health Code sets forth a long list of grounds for disciplinary action against licensed health professionals. Included is a provision expressed as "unprofessional conduct," consisting of "directing or requiring an individual to purchase or secure a drug, device, treatment, procedure or service from another person, place, facility or business in which the licensee has a financial interest." Following a long history of proceedings before the Board of Medicine and the Oakland County Circuit Court, the Court of Appeals held that "directing or requiring," as used in this section, prohibits physicians and other health professionals from referring patients to other facilities in which they have a financial interest. An application for leave to appeal that decision was filed and supported by MSMS by way of an amicus curiae brief. On March 25, 1997, the Michigan Supreme Court denied leave to appeal. This leaves the Court of Appeals' interpretation of the Public Health Code as binding law in Michigan.

Contemporaneous with the pending appeal, MSMS prepared legislation to modify this ruling. The proposed legislation would authorize referrals by health professionals to entities in which they have a financial interest if the health professional provides or directly supervises care to the patient at the other entity. If this test is not met, a number of criteria must be met, including disclosure to the patient, advice regarding alternative facilities, and provisions that the professional not be required to make referrals, that the return on the investment not be tied to the volume of referrals, that internal utilization review programs be established and that each referral must be in the best interests of the patient. Ownership of stock in a public corporation and employment by a university, hospital or other health care facility are excluded from the definition of "financial interest." Physician organizations that contract directly with employers or third-party payors to provide health care services are included in the definition of a business entity to the extent referrals are made between participating members or the physician organization. This would enable referrals to take place between separate practices within a nonintegrated physician organization, such as an IPA, without violating the law precluding referrals to another business entity.

Whether this or a similar bill will be enacted into law can only be speculation at this time. That effort must be left to the lobbyists, who will need active assistance from physicians. Opposition is anticipated. The law applies only to health professionals, not hospitals, other health care facilities or organizations. The current state of this law in Michigan, however, is intolerable. You are correct that the federal Stark legislation excludes ambulatory surgical centers from its coverage. In fact, the federal legislation has multiple safe harbors and exceptions. Physicians can carefully craft their referral arrangements to fit within the federal legislation governing Medicare and Medicaid, only to find that, under current Michigan law, no referrals to entities in which the physician has a financial interest are allowed. Ridiculous examples are limited only by one's imagination. Technically, a physician could not prescribe a drug manufactured by a company in

Editor's note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Judith Marr, Editor of Publications, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490 or e-mail her at jmarr@msms.org. **You may respond to Mr. Weber's column on-line at http://www.msms.org/**

which the physician owned stock, even if the stock was listed on a public stock exchange. Physicians under contract with a hospital might be precluded from admitting their patients to that hospital, on the basis that the contract could be interpreted to be a financial interest.

It is generally understood that the existing law applies only to a referral to another facility. Physicians may refer their patients for procedures within the physician's medical practice entity, such as a professional

corporation. For example, physicians who have xray facilities within their practice entity may have xrays taken of their patients without running afoul of the existing law. It is only when the referral is outside the physician's practice entity, to another facility or organization in which the physician has a financial interest, that the law applies.

MSMS is unaware of any enforcement action against health professionals by the Attorney General for violating the self-referral law in

Michigan. It was anticipated that there would be no enforcement action so long as this issue was pending in the appellate court. Now that the judicial appellate process has been exhausted, there could be enforcement action by the Attorney General. A violation could lead to multiple forms of discipline, including reprimand, fine, probation, suspension, revocation, limitation, community service, denial or restitution.



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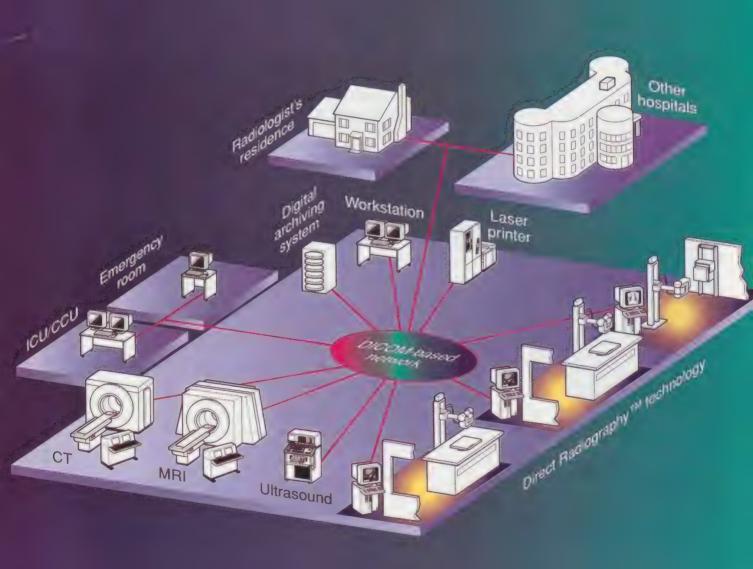
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Telemedicine:



Who's In Charge?

Nicholas Lekas, MD, FACP, an infectious disease specialist and director of the Internal Medicine Residency at Oakwood Hospital and Medical Center in Dearborn, is Chair of the MSMS Committee on Technology. According to Doctor Lekas, rural Michigan provides the greatest opportunities for telemedicine within the state.

"Telemedicine is starting to happen, and it will happen more and more as cost containment impacts on us," Lekas said, adding that legislation is necessary to insure that protections, for physicians and patients, are in place as telemedicine develops.

"As we're looking at cost containment our desire to have efficiency may but us more toward telemedicine for routine services we normally provide in our own institutions. The legislation may slow telemedicine down a little bit, but the benefits will outweigh the negatives."

Telemedicine: Who's in Charge?

By Karen Bouffard

he field of telemedicine has evolved to include exciting applications that improve access, reduce costs and enhance care. Advanced technologies — such as high-resolution digital video, codecs that convert video and audio signals to digital and back, fiber optic cable and computerized workstations stocked with a wide array of scopes and diagnostic instruments — already are reality for some physicians.

Yet, the awe-inspiring capabilities of technology are wrought with worrisome implications.

Quality of care, legal and regulatory issues, cost, confidentiality, reimbursement and malpractice are among concerns to be resolved before our medical, social and legal systems catch up with technology. MSMS will explore these issues in depth November 7 at a Technology in Medicine Symposium held in conjunction with the Society's Annual Scientific Meeting. The program will feature a keynote address by Ray Murray, MD, a specialist and practitioner of telemedicine.

As legislators, policy makers and the medical community struggle to keep pace with technological advancement, this issue of *Michigan Medicine* examines the problems, and promise, of the evolving field of telemedicine.

Quality of Care in Telemedicine

Face-to-face interaction, the doctor/patient relationship, "laying-on-of-hands," and the quality of real, three-dimensional images are an integral part of traditional medical practice. How quality of care issues are resolved may be the most powerful determinant of physicians' willingness to embrace technology.

"For health care to be effective, it can't become a commodity," says Fred Patterson, MD, president of Jackson Radiology Consultants, PC, and member of the MSMS Committee on Technology in Medicine. "Medicine is too complex an endeavor, and has a need for great individual contact and understanding. I'd rather use technology as a tool to enhance traditional care — not as a substitute."

The issue of physician responsibility is at the core of many concerns about quality of care in telemedicine. One example is in the area of telephone triage, which represents telemedicine at the first of four levels developed

in the Singer Report of Managed Care Systems and Technology. Level one involves activities such as the transfer of medical information and records over analog telephone wires, including faxes and e-mail; level two refers to activities involving image transfers, such as teleradiology and telepathology; level three includes interactive video and satellite transmission; and level four involves experimental applications such as remote palpation and robotics.

In developing a policy on centers for telephone triage, the American Medical Association determined that legal and ethical responsibilities for the medical care of patients remain the sole responsibility of physicians who are engaged in a patient care service, regardless of whether they delegate calls to a phone counseling center.

In its report, the AMA stated, "Policy must include physician direction of first and second-level triage and uninterrupted physician responsibility for delivery of medical care through phone counseling systems. The overriding principle to consider is that physicians in such systems can delegate implementation of medical care to all kinds of assistive health care professionals at their discretion; however, the responsibility for patient care can never be delegated to any one else under any circumstances."

In Doctor Patterson's practice, telemedicine is used primarily to assist on-call physicians by

transmitting images directly to their homes. While image transfer is a useful tool, it is not used for primary diagnosis.

"Right now it's good for second opinions, or for something that will later be reviewed on film," he said. "We need to be involved in the production of the image. The image needs to meet our specifications, and we need to be able to intervene in the imaging process. Radiology begins the minute the doctor thinks he needs an imaging study - and doesn't end until the radiologist has had a chance to explain the image to the referring physician. Medicine is such a unique and complex activity it relies on a high level of trust and interaction. Telemedicine should enhance but not replace people on the scene."

According to Mark D. Kolins, MD, pathologist, director of the blood bank, and vice chair of laboratories at Beaumont Hospital in Troy, more research and development of telepathology technologies have to occur before quality of care issues can be resolved.

"We haven't studied the use of telemedicine in certain areas. Can telemedicine be as efficient and effective as having the actual tissue under the microscope at the practice site? We need to study the impact of this technology on the accuracy of making the diagnosis.

"Under the microscope we can see the image at many depths of field. Telemedicine right now is just dealing with still images. With a picture you're only getting one plane of focus. In the future we'll have more active video images where the viewer will be able to see real-time focusing and image selection scanning."

Speed is also an issue. "Sometimes it can take three, four or five times longer to do it on computer. It's easier to send it via overnight mail," Doctor Kolins said. "The success of telemedicine is limited to 24 hours - because in that time I can send my materials to anywhere in the country and they will have the complete tissue or pap smear in front of them.

There are advances in speed, but the question is, 'What are we losing in diagnostic reliabilitv?"

Legislative and Regulatory Issues

Michael Sandler, MD, acting chair of the Department of Diagnostic Radiology at Henry Ford Hospital, president of the Wayne County Medical Society, and co-chair of the MSMS Committee on Technology in Medicine, says most of the legislative issues in telemedicine have to do with creating a level playing field for patients and physicians.

"If I wish to read an MRI in Michigan, I need a Michigan license," he said. "We feel that should be the same for anybody routinely taking care of Michigan patients. Patients should be protected by knowing that physicians involved in their care are licensed in this state."

Questions of how to deal with private entities like Teleradiology Associates, a Durham, North Carolina, company that reads images from 20 states, raise both economic and quality of care concerns. Many practitioners worry about the expertise and quality of unknown consultants, and some doctors voice concerns over losing their patients to distant specialists.

According to David Rovner, MD, professor emeritus of Medicine in Endocrinology and assistant to the Dean for Technology for the Michigan State University College of Human Medicine, "Telemedicine is a process whereby hopefully you can have experts at a distance at your immediate beck and call. Ultimately this could mean relying on a relatively small number of consultants from big medical organizations. Conceivably, you could take all the consultation from across the country and freeze out all the local experts.

"But how do you figure out who's the better expert?" asks Doctor Rovner, who also sits on the MSMS Committee on Technology in Medicine. "The distance expert often has only the patina of the big organization for which they work, but the local expert generally knows the patient. What's the difference between local or distant experts? One is known, and one is unknown."

Currently, 10 states have enacted laws designed to resolve issues related to interstate practice of telemedicine. Ten other states have rendered medical board rulings or state regulations that require an out-of-state physician performing a diagnosis on a patient residing in another state to possess a license to practice medicine in the patient's state.

Current Michigan law does not explicitly define the practice of medicine across state lines. This discrepancy gives the Michigan Bureau of Occupational and Professional Regulation no authority or recourse when seeking disciplinary actions against non-licensed out-ofstate physicians practicing medicine within the state.

Working with MSMS, as well as the Michigan Radiological Society and the Michigan Society of Pathologists, State Senator John J. H. Schwarz, MD (R-Battle Creek), has introduced Senate Bill 328, which would require a physician practicing telemedicine on Michigan patients to be licensed in Michigan, with all the reporting and continuing education requirements required of physicians residing within the state. Michigan licensure would be required only if the telemedicine services are provided on a regular and ongoing basis, and for "valuable consideration." It would not be required for the occasional exchange of information or opinions.

If passed, Senate Bill 328 will amend the Michigan Public Health Code's definition of "practice of medicine" to include, "diagnosis, treatment and other medically related services, including, but not limited to, the evaluation of radiographic images and pathological material, through electronic communication or any other means of communication, provided to another individual in this state."

Supporters of the bill, including MSMS, understand the urgency in seeking adequate protection for patients within the state of Michigan and ensuring that physicians who currently are not licensed in Michigan and engage in the practice of interstate medicine are held to the same practice standards and state licensing requirements.

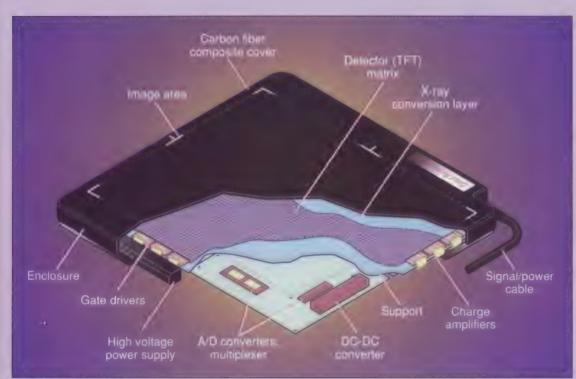
Currently, lawsuits involving doctors in one state and patients in another first would have to debate the venue: should the case be tried in the doctor's or patient's home state? At present, since no clear guidance exists regarding where a patient may bring an action against a physician, an environment might exist where plaintiffs hunt for the jurisdiction having the greatest potential for lucrative awards.

This could lead to a situation where some areas are "red lined" in terms of access to telemedicine. Since malpractice insurance is underwritten to comply with state law, insurers will have to develop new products to cover physicians who cross state lines via telemedicine.

Senate Bill 328 would resolve some of these issues by stating that physicians who engage in the practice of medicine in Michigan are "subject to the jurisdiction of the courts of this state if a cause of action is filed against the physician based on those activities." These provisions apply whether the physician is a resident of this state or of another state, territory or country.

The bill would not be a cure-all however. To date, there is no case law to clarify the role of the telephysician and his or her potential liability. Does a remote encounter constitute a physician/patient relationship, thereby creating a legal connection between the parties? For example, if a doctor in another state asks a radiologist to examine a patient's x-ray via telemedicine, has a relationship been established even though the radiologist has never met the patient?

Other issues arise with regard to credentialing. In permitting a telemedicine con-



The detector array - the heart of the Direct radiography [™] technology.

sult, is the patient's hospital granting some limited form of privileges to the consultant?

MSMS supports the position that physicians practicing telemedicine in a hospital setting within Michigan should be fully credentialed by that hospital's medical staff in accordance with the medical staff bylaws. Furthermore, physicians providing care within Michigan solely via electronic or other distant communications must be credentialed as active members of that hospital's medical staff and be held to the same standards of requisite responsibilities as other active members of the medical staff.

Economic Considerations

Medicare, Medicaid and many insurance companies generally refuse to cover telemedicine services. Third-party payers have not yet paid for consultations except for some Blue Cross Blue Shield activity in Kansas and Georgia.

Medicaid pays for interpretation of some diagnostic studies, including radiological studies. Medicaid also has piloted some limited reimbursement projects in Virginia, North Carolina and Georgia, but they historically have not paid for anything but face-to-face doctor/patient encounters.

Calculations of the costs of telemedicine must include up-front equipment expenditures, recurring costs of network services, maintenance and personnel, and intangibles such as the value of time spent learning how to use a new service, and lost opportunity costs. While still a deterrent, equipment costs have declined significantly in recent years.

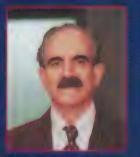
continued on page 17



Marcy L. Street, MD East Lansing



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Ali Esfahani, MD Flint



Edmund Messina, MD Lansing

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In hypertension

HE KNOWS THE PROOF IS IN THE PERFORMANCE



THAT'S WHY HE PRESCRIBES ADALAT CC

Efficacy comparable to Procardia XL®1.2 and Norvasc®*3.4

Similar safety profile[†] to Procardia XL^{1,3} and Norvasc^{3,4}

Substantially lower cost than Procardia XL and Norvasc^{‡5}

Once-A-Day



A PRACTICAL CHOICE

Adalat CC is not indicated for angina. It should be taken on an empty stomach. As with all distinct pharmacologic entities, switching from one to another may necessitate careful titration and patient monitoring.

*Procardia XL (nifedipine) and Norvasc (amlodipine besylate) are registered trademarks of Pfizer Labs Division, Pfizer Inc.

†Frequency and type of side effects are typical of dihydropyridine calcium channel blockers.⁶

‡Calculations based on suggested Average Wholesale Price (AWP).⁵ AWP is from a published price list and may or may not represent the actual price to pharmacists or consumers.

Please see brief summary of Prescribing Information on following page.



30mg, 60mg & 90mg

A PRACTICAL CHOICE

BRIEF SUMMARY CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION For Oral Use

P7500046RS

INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hyperten sion. It may be used alone or in combination with other antihypertensive agents. CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: Excessive Hypotensions: Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial intration or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomitant beta-blockers.

likely in patients using concomitant beta-blackers. Severe hypotresion and/or increased fluid volume requirements have been reported in patients who received immediate release capsules together with a beta-blocking agent and who underwent coronary artery bypass surgery using high dose fentanyl anesthers isa. The interaction with high dose fentanyl appears to be due to the combination of nifedipine and a beta-blocker, but the possibility that it may occur with nifedipine alone, with low doses of fentanyl, in after surgical procedures, or with other narrotic anal-gesics cannot be ruled out. In nifedipine-treated patients where surgery using high dose fentanyl anesthesia is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for nifedipine to be washed out of the body prior to surgery.

Increased Angina and/or Myocardial Infarction: Rorely, patients, particularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angina or acute myocardia infarction upon starting nitedipine or at the time of dosage increase. The mechanism of this effect is not established.

Into ertect is not established.

Beta-Blocker WithbdrawaL When discontinuing a beta-blocker it is important to tape its dose, if possible, rather than stapping abruptly before beginning nifedipine. Patient recently withdrawn from beta blockers may develop a withdrawd syndrome with increase angine, probably related to increased sensitivity to catecholamines. Initiation of nifedipine treatment will not prevent this occurrence and on occasion has been reported to increase it. Congestive Heart Failure: Rarely, patients (usually while receiving a beta-blocker) have developed heart failure after beginning affedigine. Patients with light partix stemosis may be at greater risk for such an event, as the unloading affect on friedignies and beta described by the patients with light partix stemostary to the patients of the patie

flow across the acritic valve.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and
titration of ADALAT Cc is suggested. Use observation is especially recommended for patients
already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dose-dependent
manner with ADALAT Cc. The placebo subtracted rate is approximately 8% at 30 mg,
12% at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought
to be associated with vasodiation of dependent arteriales and small blood vessels and
not due to left ventricular dysfunction or generalized fluid retention. With patients whose
hypertension is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Information for Patients: ADALAT CC is an extended release table! and should be
swallowed whole and taken on an empty stomoch. It should not be administered with swallowed whole and taken on an empty stomach. It should not be administered with food. Do not chew, divide or crush tablets.

food. Do not chew, divide or crush tablets:

Laboratory Tests: Rare, usually transient, but occasionally significant elevations of enzymes such as likeline phosphatose, CPK, LDH, S607, and S6Pf have been noted. The relationship to nifedipine therapy is uncertain in most case, but probable in some. These laboratory obnormalities have rarely been associated with clinical symptoms; hovever, cholestasis with or without joundice has been reported. A small increase (<5%) in mean alkaline phosphatose was noted in patients treated with ADALAT CC. This was an isolated finding and it rerely resulted in values which fell outside the normal range. Rare instances of allergic hepotitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not odversely offers sterm unit caid, glucose, cholesterol or potassium. Nifedipine, like other calcium channel blockers, decreases platelet aggregation in witro. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some niledipine patients. This is thought to be a function of inhibition of calcium transport across the platelet membrane. No clinical significance for these findings has been demonstrated. Positive direct Coombs' test with or without hemotyfic onemina has been reported but a

Positive direct Coombs' test with or without hemolytic gnemia has been reported but a causal relationship between nifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although rifedipine has been used safely in potients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinine have been reported in patients with pre-existing chronic renal insufficiency. The relationship to nifedipine therapy is uncertain in most cases but probable in some. Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been occasional literature reports suggesting that the combination of nitedipine and beta-adherancy lobekoing drug amy increase the likelihood of congestive heart failure, severe hypotension, or exacerbation of ongina in patients with cardiovascular disease. Digitalis: Since there have been isolated reports of patients with elevated digoxin levels, and there is a possible interaction between digoxin and ADALAT (Cr. or is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing ADALAT (Cr. or such according to the control of the part of the CC to avoid possible over- or under-digitalization.

ce to avoir pussue over on under-arginization.

Cournarin Anticoagulants: There have been rare reports of increased prothrombin time in politents taking coumarin anticoagulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

Quinidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of quinidine).

Interdigine With a decrease plasmin ever on quantumer, Grandfaire. Both the peak plasma level of infedipine and the AUC may increase in the pres-ence of cimetidine. Rantidine produces smaller non-significant increases. This effect of cime-tidine may be mediated by its known inhibition of hepatic cytochrome P-450, the enzyme system probably responsible for the first-pars metabolism of infedipine. If infedipine thera-py is initiated in a patient currently receiving cimetidine, courious fitration is advised.

For simulation to plants corrently extension, and controlled the properties of the p

the maximum recommended human dose. In wwo mulagenicity studies were negative. Pregnancy: Pregnancy Category C. In rodents, rabbits and mankeys, infedipline has been shown to have a variety of embryatoxic, placentotoxic and fetatoxic effects, including stunted fetuses (rats, mice and rabbits), digital anomalies (rats and rabbits), rib deformilies (mice), ethip daile (mice), small placentus and underdeveloped chorionic villi (mankeys), embryonic and fetal deaths (rats, mice and rabbits), prolonged present placents, and or about the proposition of the decreased neonal survival (rats; not evaluated in other species). On a may/kg or mag/m² bosis, some of the doses associated with these various effects are higher than the maximum recommended human dose and some are lower, but all are within an order of magnitude of it.

una some are rower, our un are winnin an oracer of magniouse on it.

The digital anomalies seen in infedigine-exposed rabbit pugs are strikingly similar to those seen in pugs exposed to phenytoin, and these are in turn similar to the phe-langeal deformities that are the most common malformation seen in human children with in utero exposure to phenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT (C should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Nursing Mothers: Nifedipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the ortance of the drug to the mother

ADVERSE EXPERIENCES: The incidence of adverse events during treatment with ADVENCE: CAPECHICLES: The Incloner or older's events ouring treatment with ADALAT CC in does up to 90 mg daily were derived from multi-center placebo-controlled clinical trials in 370 hypertensive patients. Atenolol 50 mg once daily was used concomi-tantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo. All olderse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

The most common adverse event reported with ADALAT® (C was peripheral edema. This was dose related and the frequency was 18% on ADALAT (C 30 mg daily. 22% on ADALAT (C 60 mg daily and 29% on ADALAT (C 90 mg daily versus 10% on placebo.

Other common adverse events reported in the above placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Fusique/osthenia (4%, versus 4% placebo incidence); Dizziness (4%, versus 2% placebo incidence); Fusique/osthenia (4%, versus 4% placebo incidence); Musea (2%, versus 1% placebo incidence); Constipation (1%, versus 0% placebo incidence); Ostatopation (1%, versus 0% placebo i

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90~mg:

Body as a Whole/Systemic: chest poin, leg poin Central Nervous System: paresthesia, vertigo Dermatologic: rash Gastrointestinal: constipation Musculoskeletal: leg cramps Respiratory: epistaxis, rhinitis Urogenital: impo-

Other adverse events reported with an incidence of less than 1.0% were

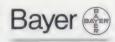
Unter daverse events reported with an incuence of test man trace week. Body as a Whole /Systemic cellulitis, child, facial edemo, neck pain, pelvic pain, pain Cardiovasculars atrial fibrillation, bradycardia, cardior arrest, extrasystole, hypotension, palpitations, phlebitis, postural hypotension, tachycardia, cutaneous anglectases Central Nervous Systems anxiety, confusion, decreased libido, dopression, hypotension, polpitations, phlebitis, postural hypotension, tachycardia, culaneous angiectases Central Nervous System: anxiety, confusion, decreased libido, depression, hypertonia, insomnia, somnolence Dermatologic: pruritus, sweating Gustrointestinal: abdominal pain, diarrhea, dry mouth, dysepsia, esophogisis, flatulence, gastrointestinal hemorrhage, vamiting Hematologic: lymphadenopathy Metabolic: goul, weight loss Musculoskeletal: arthralgia, arthritis, myalgia Respiratory: dyspnea, increased cough, rales, pharyngiis: Special Senses: abnormal vision, amblyopia, conjunctivitis, diplopia, tinnitus Urogenital/Reproductive: kidney calculus, nocturio, breast engorgement

The following adverse events have been reported rarely in patients given nifedipine in other formulations: allergenic hepatitis, alopecia, anemia, arthritis with AMA (+), depression, erythromelalgia, exfoliative dermatitis, lever, gingival hyperplasia, gynecomastia, leukopenia, mood changes, muscle cromps, nervousness, paranoid syndrome, purpura, shakiness, sleep disturbances, syncope, toste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urticaria.

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References

1. Glasser SP, Ripa SR, Allenby KS, Schwartz LA, Commins BM, Jungerwirth S, on behalf of the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine Administered without Food: The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Hypertension. Clin Ther. 1995;17(2):296-312. 2. Glasser SP, Jain A. Allenby KS, Shannon T, Pride K, Pettis PP, Schwartz L, MacCarthy EP, and the Nifedipine Study Group. The Efficacy and Safety of Once-Daily Nifedipine The Coat-Core Formulation Compared with the Gastrointestinal Therapeutic System Formulation in Patients with Mild-to-Moderate Diastolic Hypertension. *Clin Ther.* 1995;17(1):12-29. **3.** Data on file, Bayer Corporation, Pharmaceutical Division. **4.** Zidek W, Spiecker C, Knaup G, Steindl L, Breuer H-W, on behalf of the Hypertension Study Group. Comparison of the Efficacy and Safety of Nifedipine Coat-Core Versus Amlodipine in the Treatment of Patients with Mild-to-Moderate Essential Hypertension. Clin Ther. 1995;17(4):686-700. **5.** Redbook Update. Montvale, NJ, Medical Economics Data, Inc., December 1996. 6. Adalat® CC Product Monograph, April 1995.



Pharmaceutical Division

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Made in U.S.A and Germany continued from page 15

Nonetheless, equipment costs remain the largest barrier for many physicians interested in telemedicine, according to MSMS Chief of Internet Systems William R. DeCourcy, Jr.

"Currently the telemedicine links one needs are quite expensive – especially in rural areas where telemedicine is needed the most," he said.

According to DeCourcy, beginning in January 1998 Universal Service Funds will be made available to rural healthcare providers for creation of telehealth links.

Because telemedicine consultations are rarely reimbursed, cost analysis is difficult.

Telemedicine services often are undertaken to control the costs of healthcare. In rural areas, the goal is to control the cost of transportation and distant referral. In urban areas, the goal often is to keep patients at their local facilities, avoiding lost revenue.

In both environments, telemedicine has been used to provide physician supervision of nurses, nurse practitioners and physicians assistants. The potential for non-physician healthcare providers taking increased responsibilities has long been a tenet of telemedicine.

One study examined whether physicians could be replaced with nurse practitioners assisted by telemedicine links. It concluded that pediatric nurse practitioners could function with televised consultation, rather than on-site supervision, 40 percent of the time.

Perspectives on Telemedicine

While society struggles to resolve medical, social and political barriers to telemedicine, its current and potential benefits are great.

Teleradiology can provide the services of a radiologist to remote locations that do not have

TELEMEDICINE IN PRACTICE IN MICHIGAN

Recently, neonatologists with the Regional Medical Center at Marquette General Hospital (MGH) faced a familiar dilemma when one patient's fetus, at 20 weeks of gestation, was diagnosed with an anterior abdominal wall defect. The defect would require surgical repair, ideally within six to eight hours of birth. No pediatric surgeon would be available at MGH to perform the delicate procedure.

Due to the availability of equipment through the Upper Peninsula Telehealth Network (UPTN) University of Michigan physicians were able to lessen this patient's burden by conducting pre- and post-natal exams via telemedicine. Rather than driving nine hours to Ann Arbor for each doctor's visit, mother and fetus were followed with serial live ultrasound examinations viewed from 500 miles away by surgeon Daniel Teitelbaum, MD, and perinatologist Clark Nugent, MD, of Mott Children's Hospital.

According to Doctor Teitelbaum, Mott Children's Hospital has been involved in 18 such cases since establishing its telemedicine system. Mott's telemedicine program was established to provide rural access to tertiary and quaternary medical specialists, to lessen inconvenience to rural patients, and to provide opportunities for simultaneous involvement of multiple specialists and primary care physicians on complex patients. Mott's telemedicine system connects the hospital to two major regional telemedicine communication facilities in the state: UPTN and the Rural Emergency Medical Education Consortium (REMEC) which serves 20 counties in northern lower Michigan and the eastern Upper Peninsula.

continued on next bage

a local radiologist. Telemedicine also can ac- example, different states have different requirecelerate diagnosis and treatment by reducing ments for disclosure of the names of AIDS pathe time required for patients to be seen by their tients – it's likely that security programs can be family physician, then be referred to other lo- developed to resolve these issues. cations, travel to those locations, receive spefamily physician.

exist with regard to shared interstate data – for enue to the hospital and community.

Telemedicine can reduce costs, not only cialty care, return home and then revisit their through telephone triage, but by decreasing the duplication of services, technologies and spe-According to the Institute of Medicine, 30 cialists. One specialist can provide services to a percent of physicians could not access patient's number of locations using telemedicine. Rural records; 70 percent of hospital records were in- physicians can reduce the costs of emergency complete; and 22 percent of people in hospitals on-call services by using telemedicine so that depended on access to patient records at a given each physician does not have to be on call each time. Telemedicine can greatly enhance record night in his or her own location. When need keeping, saving the time often required for pa- exceeds the number of physicians available, tient records to be dictated, transcribed, and sent telemedicine can provide remote physician suto referring physicians. Everyday confidentiality pervision to para-professionals. In addition, issues can be resolved by encrypting the data or small rural hospitals can be enabled to deliver limiting access with passwords. While problems health care locally, resulting in increased rev-

Quality of care can also be improved through we use, and probably won't be the optimal way. telemedicine. With telemedicine consultations, the referring physician, consulting specialists comes will really drive how we practice in the and patient often gather together through in- future. And medicine is better when all of the teractive video.

Telemedicine has also been shown to decrease professional isolation by providing op- more; to provide services at a more convenient portunities for peer and specialist contact, as place.' well as for continuing medical education.

Doctor Kolins believes telemedicine, in the end, will be just one more tool among many utilized by physicians.

"I think it's going to be a tool for consultation. When you have a tough case, you e-mail your friend via the EEG and say, 'What do you think is going on?'

"The best medicine is practiced locally. Faceto-face meetings are generally more productive. Telemedicine will just be one of those things

"Patients' perceptions of quality and outpatient's care is aggregated at one site.

"Telemedicine is just a tool to allow us to do

"Telemedicine in Practice in Michigan" continued

telemedicine is telepsychiatry, which is widely practiced by MGH psychiatrists. MGH psychiatrists practice telepsychiatry with patients at Schoolcraft Community Mental Health. They also provide telepsychiatry to inmates Fly, Director of REMEC. from the Department of Corrections at various locations throughout the Upper Peninsula, cated leased T-1 line at each of 13 member and work with psychiatrists at the Duane Waters Hospital in Jackson.

REMEC, formed in 1993, provides telemedicine links between 11 independent regional hospitals, an air/ground ambulance Fly added, is that it can link with out-of-sysservice, medical control authority and a local college.

Michigan and the eastern Upper Peninsula. The 20-county-area covers 12,166 square

Among various applications for gency department physicians, nurses and EMTs who are geographically and professionally

> "The whole purpose of REMEC is supplying health access to rural areas," said Dan

The system features a CODEC and dedisites. The CODEC, or "compression/decompression" equipment, is central to transmitting video images in real-time, according to Fly. A powerful feature of the REMEC system, tem networks, allowing for collaboration with UPTN, the Mott system, or other networks. The REMEC system covers northern Lower REMEC is linked with the Michigan Collegiate Telecommunications Association (MiCTA.)

Recently, REMEC worked with Doctor miles with a population of 399,126. North- Teitelbaum to facilitate the telemedicine exern Michigan EMS providers including emeramination of a child experiencing difficulty with a feeding tube.

needed to be monitored, but to make the trip in Plymouth. just for that would be difficult." Doctor Teitelbaum recalled. "Using a document cam- missions simultaneously. Our peripheral era, and with the assistance of a registered nurse and the family doctor, we visually took down the dressing and performed an exami-

Michigan prisons are home to the most extensive use of telemedicine in the state. According to Telemedicine Coordinator Lynette Holloway, of the Bureau of Healthcare Services, Michigan Department of Corrections, more than 400 telemedicine consults were March 1996 and April 1997.

at Duane L. Waters Hospital in Jackson to remote sites at Brooks Correctional Facility in

Muskegon, the Gus Harrison Correctional Fa-"The child was having problems with it. It cility in Adrian and Scott Correctional Facility

"We're using video, audio and data transequipment consists of an otoscope and an electronic stethoscope. The cardiologist at Duane Waters can in real-time hear heart and lung sounds of patients at remotes sites, rather than just viewing an EKG," Holloway said.

The Department of Corrections telemedicine program, which started in 1996. has 14 different subspecialists under contract to provide remote consults, Holloway adds.

"Telediognostics has helped us reduce the conducted at correctional facilities between number of transportation runs to Duane Waters Hospital," Holloway said. "Also, it seems Telemedicine is conducted through a base to be easier to schedule a telemedicine consult than to arrange an on-site visit."

MSMS September

17, MSMS/MPMLC Risk Management Seminar. "Anatomy of a Lawsuit." Location: MSU Management Conference Center, Trov. Contact: Liz Treanor, (810) 748-0465, ext. 288.

- 18, MSMS/MPMLC Risk Management Seminar. "Anatomy of a Lawsuit." Location: Horizon Conference Center, Saginaw. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 23, MSMS/MPMLC Closed Claim Review. Location: Novi Hilton, Novi. Contact: Darla Brandon, (517) 336-5769.
- 24, MSMS Board Meeting. Location: MSMS headquarters. Contact: Irene Frost at MSMS at (517) 336-5734.
- 25, MSMS/MPMLC Risk Management Seminar. "Physician Criminal Exposure." Location: Kalamazoo. Contact: Liz Treanor, (810) 748-0465, ext. 288
- 26-28, MSMS Mackinac Island Conference on Bioethics. Contact: David Fox at MSMS at (517) 336-5731.
- 26-28, Upper Peninsula Medical Societies Annual Meeting. Location: Houghton. Contact: Mark Shebuski, MD, (906) 487-1710.

October

7, MSMS/MPMLC Closed Claim Review. Location: Holiday Inn, Saginaw. Contact: Darla Brandon, (517) 336-5769.

- 14, MSMS/MPMLC Closed Claim Review. Location: Ramada Inn. Marquette. Contact: Darla Brandon, (517) 336-5769.
- 15, MSMS/MPMLC Closed Claim Review. Location: Days Inn, Escanaba. Contact: Darla Brandon, (517) 336-5769.
- 15, MSMS/MPMLC Risk Management Seminar. "Radiology." Location: Holiday Inn Gateway Centre, Flint. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 16, MSMS/MPMLC Risk Management Seminar. "Physician Criminal Exposure." Location: MPMLC Headquarters, East Lansing. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 21, MSMS/MPMLC Seminar. "Negotiating Safe Passage in a Changing Healthcare Environment." Location: University Club, Flint. Contact: Darla Brandon, (517) 336-5769.
- 25, MSMS/MSMSA "Michigan Doctors and Their Families Make a Difference Tailgate for Charity." Location: Spartan Stadium, East Lansing. Contact: Sheri Greenhoe, (517) 336-7603.
- 28, MSMS/MPMLC Closed Claim Review. Location: Amway Grand Plaza, Grand Rapids. Contact: Darla Brandon, (517) 336-5769.

AMA

September

17-18, Political Grassroots Conference. Location: Marriott, Washington, DC. Contact: AMA Department of Registration Services, (800) 621-8335.

SPECIALTY SOCIETIES

September

11-12, Michigan Medical Group Managers Association. Location: Grand Rapids Amway Grand Plaza. Contact: Debbie Zannoth at MSMS at (517) 336-5763.

- 12, Michigan Society for Respiratory Care. Location: MSMS headquarters, East Lansing. Contact: Caroline Kimmel, (517) 336-7587.
- 17, Michigan Vascular Society Meeting. James Stanley, MD, will discuss the American Board of Vascular Surgery. Location: Novi Hilton, Novi, 6:00 p.m. Call for reservations prior to September 12, (616) 459-8700.
- 26-28, Upper Peninsula Medical Societies Annual Meeting. Location: Houghton/Hancock. Contact: Ronald Bissett, MD rbissett@up.net.
- 30, Michigan Health Management Information System Conference. Contact: Barbara Horwitz at MHMIS at (313) 963-4990.

October

3, Michigan Department of Community Health Regional Immunization Conference. Location: Lansing. Contact: Rosemary Franklin, (517) 355-9485.

- 4, "Every Woman's Health Forum." Location: Mawby Education Center, Battle Creek. Contact: (616) 966-1453.
- 14, Michigan Department of Community Health Regional Immunization Conference. Location: Boyne Mountain. Contact: Rosemary Franklin, (517) 355-9485.
- 16, Michigan Department of Community Health Regional Immunization Conference. Location: Marquette. Contact: Rosemary Franklin, (517) 355-9485.
- 31, Michigan Department of Community Health Regional Immunization Conference. Location: Ypsilanti. Contact: Rosemary Franklin, (517) 355-9485.

November

4, Michigan Department of Community Health Regional Immunization Conference. Location: Ypsilanti. Contact: Rosemary Franklin, (517) 355-9485.

- 7-9, Michigan Association of Medical Examiners Annual Meeting. Contact: Melissa Wiegand at MSMS at (517) 336-7586.
- 21, Michigan Committee for Prevention of Child Abuse. Location: MSMS headquarters. Contact: Jean Smith at MSMS at (517) 336-5604.



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Nurses' Claims Unsubstantiated

By Tom M. George, MD



n a June 11 Column of Health Care Weekly Review, I showed how the Michigan Nurses Association's (MNA), claim that "advanced bractice nurses have comparable—if not more pharmacology training as physicians," was inaccurate because it equates undergraduate-level nursing classes with graduate-level medical school courses. and because it totally ignores physician's post-graduate residency training. In their response, (Doc Misleads Public on "Right to Write" issue, Health Care Weekly Review, June 18) the MNA raised another issue that also deserves to be refuted.

This is the oft-repeated claim that granting advanced-practice nurses prescriptive privileging will somehow lower health care costs. The MNA argues that "numerous studies have found that care provided by APNs is less expensive" than the care provided by physicians, and that therefore "they must be allowed to complete the treatment by writing prescriptions." This assertion was also made last year as part of an MNA press release entitled "Why Michigan Employers should Support Independent Prescriptive Authority for APNs." The press release includes a list of the 15 studies that purportedly support their position.

A review of the cited studies reveals that they are, in effect, an endorsement of the current law. None of them even mention prescriptive privileging and they certainly fail to demonstrate what effect prescriptive privileging, or the independent practice of nurses, would have on health care costs.

One of the "studies" cited was only a press release entitled "Getting the Art of Obstetrics," Kaiser Permanente press release, March 30, 1993. Two other studies were either unpublished or the publishing journal was not given by the MNA ("A Comparison of CNM and MD Care 1989-1993" and "National Association of Childbearing Centers Survey Report of Experience 1987-1989"). The remaining studies only examined practice settings where APNs are dependent on physician supervision.

For example, the MNA cites the article "Certified Nurse-Midwife Effectiveness in the Health Maintenance Organization Obstetric Team" from Obstetrics & Gynecology (1989;74(1):112-116). In this report, the authors are careful to mention that the care given was "interdisciplinary," that "both types of professionals worked to-

gether on each case," that "physicians were immediately available in the hospital," and that the "certified nurse midwives worked closely with physicians." This is not an endorsement of independent practice.

The MNA also cites the article, "Nurse Practitioner Role in a Chronic Congestive Failure Clinic," from Heart and Lung (1983;12(3):237-239) that reports costs savings when patients saw a nurse practitioner in a VA hospital clinic. This article states, "The overall therapeutic care for the nurse practitioner clinic was designed and supervised by the same staff physicians who had followed the patients (earlier)." This report has nothing to do with independent practice or prescriptive privileging either.

Other articles such as "The Impact of Nurse Anesthetists on Anesthesiologists' Productivity" (Medical Care, 1990;28(2):159-169), project what savings might be realized if more care was given by teams of APNs working under the supervision of physicians. As in the other articles, savings are not contingent on prescriptive privileging and the study assumes physician supervision.

In making its "cost savings" argument to Michigan employers, the MNA also conveniently

fails to mention the ongoing national efforts by APNs to achieve "equal pay for equal work." The nursing lobby has been so effective in obscuring the difference between doctors and nurses that many reimbursement plans fail to make a distinction. For example, Medicare, Michigan's Worker's Compensation Fee Schedule, and most commercial carriers now pay nurse anesthetists who work under a surgeon's supervision the same as anesthesiologists. Blue Cross Blue Shield of Michigan, because it pays for hospital-employed nurse anesthetists using a "cost-pass through system," (whereas physicians' payment is capped), can actually pay more for nurse-administered anesthesia. The MNA fails to show how paying nurses the same as physicians lowers health care

Likewise, the MNA studies, which are all based on nurses working collaboratively with physicians, cannot be used to show that nurses working independently provide "equal work." Even the MNA admits that with prescriptive privileging there would still be a need for "referral" to physicians when in the "nurses opinion," the "clients" care exceeds the nurse's "scope of practice." If autonomously working nurses have a skill level that is less than physicians, but they expect to be reimbursed the same, then what they are really seeking is "equal pay for a lesser service." If a patient then sees a physician, all that has been accomplished is unbundling of the nurse and physician components of care.

Perhaps the best endorsement for continued physician supervision is found in the MNAs own press release, "a study conducted at the University of Michigan . . . found a significant cost savings of \$1,000 per case when nurse-midwives provided the service . . . " Apparently this cost savings was realized in spite of (or because of), Michigan's requirement for physician supervision. This and other studies cited by the MNA are merely an endorsement of Michigan's cur-

The author is a past-president of the Kalamazoo Academy of Medicine. He is a partner in a large group medical practice that employs 32 APNs.

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Better Health Care Legislation

Dianne Byrum works for legislative reform



By Kristen M. Lare

ealth care legislation is of key interest to many citizens of Michigan today. State Senator Dianne Byrum (D-Lansing) has worked diligently as an advocate in health care legislation over the past three years, and continues to develop safeguards for patients in the managed care and insurance systems. Sen. Byrum hopes to create legislation that will "engage Michigan in dialogue on public policy aspects of health care and how it's changing in terms of providers and consumers." She currently serves as the Democratic Vice-Chair of the Senate Health Policy Committee and recently worked at the committee level on the Patient Bill of Rights—which was signed into law on December 31, 1996.

Sen. Byrum is currently working on a health care package. This multi-faceted package would enable the state to maintain access and quality during the rapidly changing trend toward managed care. Sen. Byrum sees this package putting "issues on the table as they relate to health care in transition."

Sen. Byrum envisions the package as a starting point for a long-haul discussion—not a single-issue attempt to address health care. This pending legislation will "allow us to be participants in the national debate instead of spectators," she says.

A bipartisan group of state legislators from nine states has developed a model bill called the "Managed Care Consumer Act," now being introduced in New Jersey. While Sen. Byrum has identified pieces of this bill and legislation in other states that will work for Michigan, most of her bill is unique to the state's needs. It will, she contends, put the state in a league with those states already addressing managed care issues.

One of the most important components of Sen. Byrum's health care package is the creation of a patient ombudsman office. This autonomous entity would serve to advise and provide information trends to the legislature—to act as a regulatory framework—during this time of transition in health care. As an interpreter, the ombudsman would also link Michigan doctors to the legislature on quality of information in a "big-picture" view as decisions in health care become increasingly more com-

Additionally, Sen. Byrum, along with Sen. Jon Cisky (R-Saginaw), is working on a separate package of bills that would prohibit allowing domestic vio-

lence to be cited as a pre-existing condition for insurance underwriting purposes. This new legislation would make this practice illegal. It is currently pending in a House committee.

Over the past few months, Sen. Byrum has been consulting with people who represent points all along the health care spectrum, including the Michigan Partners for Patient Advocacy Coalition (MPPA), the American Association for Retired People (AARP), the Service Employees International Union (SEIU), the Michigan Health and Hospital Association and MSMS. She has, along with her staff, conducted a state-wide mailing with a return feedback form, and they also have established a presentation about managed health care issues that was shown to health care providers, legislators and other groups.

These efforts have generated an enormous amount of positive feedback, which enables Sen. Byrum to stay up-to-date on current trends and concerns, as well as increase her own body of knowledge regarding the delivery and handling of health care. Sen. Byrum relies very heavily on the medical community as a resource,

and hopes to strengthen this relationship further in the future.

The MPPA was absolutely integral in the formation and passage of the Patient Bill of Rights. "It's very doubtful," says Sen. Byrum, that the legislation would have passed without the input and action from the MPPA, in which MSMS is an active member. Sen. Byrum feels that the coalition is a vital part to any current health care legislation because they "create a network and support mechanism that stretches across the state, pointing out concepts and the need for necessary changes in the laws."

When asked about her future plans, Sen. Byrum stated that she plans to run for reelection to the Michigan Senate in 1998—and for reappointment to the Senate Health Policy Committee.

In closing, Sen. Byrum has a message for Michigan doctors: "Get involved. You need to get to know your local elected officials and have a dialogue with them because you can make a difference."

To find out how to get involved at the grassroots level, contact Greg Aronin at MSMS at (517) 336-5741 or at garonin@msms.org. ■

The author is MSMS Editorial Assistant for Michigan Medicine.

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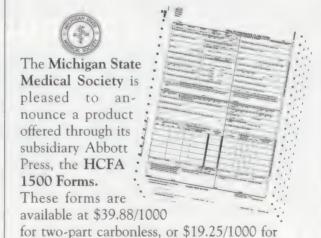
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Medicare Preservation

Alive and well in Washington



By U.S. Congressman Dave Camp

The House of Representatives Committee on Ways and Means, of which I am a member, in a recent bipartisan 36-3 vote, preserved Medicare while giving senior citizens more choices for their health care coverage.

The movement on Medicare preservation this year reflects a growing recognition that neither republicans nor democrats—and least of all, senior citizens—were served by the demagoguery that turned the Medicare issue into a political football in 1995-96.

There are good reasons behind Congress' new-found spirit of cooperation. The President's own Medicare trustees reports have grown more and more ominous. According to its most recent annual report, the Medicare Trust Fund will go bankrupt in 2001, having already lost \$16 billion since 1995, when Congress made a major attempt to save the system with the Republican-vetoed Medicare Preservation Act. In fact, since October 1, 1996, the Hospital Trust Fund has lost more than \$4 billion and will continue to lose money until it goes bankrupt unless we enact these important reforms.

This time around, however, the President is hailing Republican efforts as a "constructive step forward," an illustrative comment on the heightened sense of urgency in Washington to save the system.

Particularly encouraging is the inclusion of a demonstration project that tests how medical savings accounts (MSAs) would work in the Medicare program. The proposal allows up to 500,000 senior citizens to put Medicare money into a tax-exempt account, which could be used to pay for qualified medical expenses. Beneficiaries who choose the accounts would be required to select a government-provided highdeductible health insurance policy to cover catastrophic injuries or illnesses. Enrollment would begin January 1, 1999, and end December 31, 2002, at which point any Medicare beneficiary with a savings account could keep it.

The latest effort also restores solvency to the dwindling Hospital Insurance Trust Fund and prepares it for the retirement of the massive baby-boom generation.

beginning in the year 2010.

Included in the proposal, which is the subject of further committee action in June, is an amendment to increase payments for managed care organizations in rural areas and other parts of the country with historically low health care costs. While the bill already proposes an increase in payment rates for low-cost areas, the change was needed to encourage the growth of managed care in places where payments have been too low to attract health care providers.

Much of the Trust Fund savings, however, comes from a home health care cost shift from Medicare part A to part B. While this cost shift preserves the fund for 10 years, it does nothing to address the long-term costs associated with home health care. Home health care costs had an annual growth rate of 35 percent between 1989 and 1995, increasing from \$2.6-\$16 billion.

Home health care services are expected to cost \$31.3 billion by 2002. Unless a way is found to reduce costs through legislation or by providers themselves, these costs will remain a threat to Medicare beneficiaries, providers and American taxpayers as well.

In the coming months, the Medicare proposals will be folded into the budget proposal moving through Congress that balances the budget in five years. As in the past, Medicare preservation will be a central issue to on-going negotiations. If the recent Committee cooperation between republicans and democrats in the House is any indication, however, both health care providers and beneficiaries alike can look forward to an agreement that preserves Medicare for today's senior citizens and future generations.



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Jack Stack, MD

Small town physician with a big impact



By Ralph Ward

Physicians from small towns often are able to have a very large impact on people's lives. Perhaps that is one reason that Jack Stack, MD, of Alma has earned fame and respect both in the mid-Michigan area and throughout the state.

Doctor Stack, who has practiced in obstetrics, gynecology, psychiatry and family practice, has been a leader in child care and social issues for 30 years and often took controversial stands. He is perhaps better known for his early advocacy of legalized abortion, but Doctor Stack's activities extend to many other areas. He con-

ducted much of the primary research in the field of infant mental health, founding the *Infant Mental Health Journal*. He has served as trustee for Michigan State University, and in this capacity, in the early 1980's, spearheaded MSU's then-landmark

decision to disinvest in South Africa. For his part in this action, which was one of the first in the United States to bring apartheid concerns to light, he later received a personal citation from Nelson Mandella.

Throughout his career, Doctor Stack has continued his work with mothers, children and

PHYSICIAN PROFILE

Cassandra Klyman, MD

Making a difference for women

eptember is "Women in Medicine" month, and the new chair of the MSMS Committee on Concerns of Women Physicians brings unique insights to the health needs of women—both their mental and spiritual health. Cassandra Klyman, MD, has pursued her interest in psychiatry for the 30 years she has been in practice. Along with her private practice in Bloomfield Hills, she is an assistant clinical professor at Wayne State University's College of Medicine in the psychiatry department, as well as a senior attending physician at Sinai-Detroit Medical Center.

Doctor Klyman's area of specialty is female psychosexuality, anxiety and affective illness and couples therapy. "I like waking up in the morning and knowing I can help patients understand themselves, and gain mastery over the decisions they make."

Addressing the professional needs of women in medicine always has been important to Doctor Klyman. She is past-president of the Michigan Psychiatric Society, has served as chair of the MDs legislative committee and is a member of the Society's ethics

prenatal care, and was instrumental in creating the Department of Family Practice in the College of Nursing at MSU. According to friend and long-time supporter Nancy Lewis of Mt. Pleasant, Doctor Stack is "unique in making the connection between early childhood issues and the prenatal experience. He has dedicated so much of his life to trying to improve life's beginnings." His latest effort is a state-wide perinatal coaching program. Through this program, at-risk pregnant women—typically teens—are paired with volunteer mothers, who mentor the young women from the early stages of pregnancy until the child is three years old.

To gain financial support for this new program, and to recognize Doctor Stack on his "semi-retirement," friends are holding a major tribute/benefit in his honor on September 28, 1997. The luncheon event, set for the Kellogg Center at MSU, will feature remarks by Doctor Stack on the need for better perinatal care, as well as tributes from state dignitaries. Tickets for the program are \$25, and are available by calling Nancy Lewis at (517) 773-2438 or Molly Minnick at (517) 224-6999.

and program committees. With MSMS, she has served on the Committee on Concerns of Women Physicians for 15 years, and has also been active in lobbying for the concerns of psychiatrists and psychoanalysts in the state.

Childhood interests inclined Doctor Klyman toward medicine. "I read a lot as a kid," she recalls. An interesting medley of "Prince Valiant and Wonder Woman comics, plus Russian novels" piqued her interest in people, and ultimately their health and mental processes. Her specific interest in psychiatric and women's issues came about in an equally unorthodox style. While working her way



Cassandra Klyman, MD

through college, she earned a few dollars on the side as a test subject in sleep research. This program, under the direction of noted researcher William DeMent, consisted of letting the patient watch "a rapidly revolving drum with subliminal sexual stimuli printed on it

just before going to sleep." At the time, the sleepy young student didn't catch the point of the whole thing, but reported some very intriguing dream symbolism. "This led me to look into dream therapy, and ultimately into psychiatry," she recalls.

The author is a Riverdale-based freelance writer.

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MSMS Annual Scientific Meeting November 5-7, Dearborn

By Colleen M. Horton

This year, participants of the 132nd MSMS Annual Scientific Meeting will find some major changes. The meeting, scheduled November 5-7, 1997, will return to the Hyatt Regency Hotel in Dearborn after being held in Lansing for the last two years and at the Dearborn Inn prior to that.

The meeting will begin on Wednesday, November 5, with registration at 6:30 a.m. and the first courses starting at 8:30 a.m. Among those being offered is "Pain Management," sponsored by the MSMS Committee of Hospice Medical Directors and presented by Thomas M. George, MD, of Kalamazoo. This course will provide practical information about palliative medicine through several half-hour presentations.

On Thursday, November 6 the day will begin with a plenary session on "Cancer Screening and Prevention." The course director is Ronald M. Davis, MD, and the sponsor is Henry Ford Health System. Cancer risk reduction will be emphasized with a focus on smoking cessation and dietary counseling. Raymond Y. Demers, MD, of the Henry Ford Health System will speak, as will Doctor Davis.

New Technology Symposium

A new feature of this year's Annual Scientific Meeting will be a technology symposium on Thursday, November 7. It will include a handson introduction to computers via the use of a computer lab. A plenary session will overview medical technology. Among the speakers for this



symposium will be David Rovner, MD, College of Human Medicine at Michigan State University; Ray Murray, MD, Department of Medicine, Michigan State University, and Barbara Hurwitz from the Greater Detroit Area Health Council.

Friday, November 7, Robert J. Desnick, MD, PhD, will present the plenary session on "Gene Therapy." This session is an introduction for primary physicians and specialists to the principles of gene therapy including recent experiences and future prospects.

Office Staff Welcome

Another new feature of the 1997 Annual Scientific meeting will be a segment of courses relating to the business aspect of running the physician's practice. "Designing Business Strategies" will be presented on Wednesday morning by course directors Kenneth M. Hekman, FACPME, and David Kepley. The purpose of this course is to demonstrate how strategic business planning can serve to extend and protect the viability of physician practices. "Mergers and Consolidations," "Peer Review-New Dimensions & New Importance" and "Prescription Costs" also will be offered.

Physicians are encouraged to enroll their office managers and staff in courses designed to educate and inform them about the importance of customer service. Offered this year for the first time, "Customer-Oriented Medical Practice Part 1 and Part 2" will stress the importance of customer service in the medical practice and the role of the office staff member in promoting a customer oriented atmosphere. Through group discussion, creative ideas for enhancing the patient's satisfaction with care will be explored with emphasis placed on solving common patient complaints—the telephone, the reception/waiting area and the collection process.

Another important course designed for physician and staff is "E-M Coding & Documentation." This course will discuss in detail the decision process, definitions and the documentation guidelines that HCFA and other payers will use to determine whether the proper code(s) were submitted. Tips on documentation, key diagnosis coding guidelines including 1998 changes will be discussed.

Thursday and Friday morning plenary sessions are free and begin at 7 a.m. Morning courses run from 8:30 a.m. until poon with lunch from noon to 1:30 p.m. Afternoon courses begin at 1:30 p.m. and end at 5 p.m.

For details about the meeting and registration information, contact James Tarrant at MSMS, (517)336-5591, or at jtarrant@msms.org.

The author is MSMS Communications Assistant.

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8:30 a.m. to Noon, including break

Basic Cardiac Life Support

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Pediatrics: Pearls & Pitfalls Radiology for Clinicians

*Designing Business Strategies that Work for You

*The Customer-Oriented Medical Practice, Part 1

WEDNESDAY LUNCH (NO FEE)

WEDNESDAY AFTERNOON, NOV. 5

1:30 p.m. to 5 p.m., including break

Basic Cardiac Life Support

Pain Management and End-of-Life Care

Frequently Encountered Neurological Problems

Quality Improvement in Cardiovascular Care

Obesity Management

Peer Review - New Dimensions & New Importance

*The Customer-Oriented Medical Practice, Part 2

THURSDAY MORNING, NOV. 6

"Early Bird" Plenary Session

Cancer Screening & Prevention in Primary Care

7:15 a.m.-8:15 a.m., No Course Fee

8:30 a.m. to Noon, including break

Basic Cardiac Life Support

Allergic Rhinitis & Latex Allergy

Breast Cancer Therapy: A Multi-Specialty Approach

Recognition & Treatment of Common Traumatic

and Athletic Orthopaedic Injuries in Children

Guidelines in the Multidisciplinary Management

of Prostate Cancer

*Mergers, Consolidations and Fair Market Value

A Physician's Guide to Evaluation & Management

Coding & Documentation

All lunches will be served from Noon to 1:30 p.m.

THURSDAY LUNCH (NO FEE)

THURSDAY AFTERNOON, NOV. 6

1:30 p.m. to 5 p.m., including break

Management of Chronic Pain in Theory & in Practice

The Spectrum of Anaphylaxis

Nuances of Breast Reconstruction

Orthopaedic Sports Medicine Approach to

Occupational Injuries

Saving the Diabetic Foot

Breast Cancer Diagnosis: Medical and Legal Risk

Management Principles

*Regulations in the Physician's Office:

Who's Looking Over Your Shoulder?

FRIDAY MORNING, NOV. 7

"Early Bird" Plenary Session

Gene Therapy: Recent Results & Future Prospects

7:15 a.m. - 8:15 a.m., No Course Fee

8:30 a.m. to Noon, including break

Hypertension Review

What's New with the Nose?

Risks & Benefits of Menopausal Hormone

Replacement Therapy

Save 100: Intro to Quality, Cost-Effective Prescribing

Technology Symposium - Part 1

Hands-On Intro to Computers & the Internet

FRIDAY LUNCH (NO FEE)

FRIDAY AFTERNOON, NOV. 7

1:30 p.m. to 5 p.m., including break Immunizations for a Lifetime

Colon & Rectal Surgery

Addressing Sexual Difficulty, Distress &

Dysfunction in Primary Care Practice

Food & Chronic Illness

Technology Symposium, Part 2

Hands-on Intro to Computers & the Internet

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MSMS Members with "retired status": \$35 per course

Residents: \$35 per course

Non-Members: \$85 per course

Nurses: \$65 per course

Students: No Course Fee

**NOTE: Each attendee must pay a \$25 one-time registration fee. Includes registration materials, handouts, refreshments, and plenaries.

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x \$35 (retired & residents) = \$

x \$85 (non-members)

x \$65 (nurses)

x \$0 (students)

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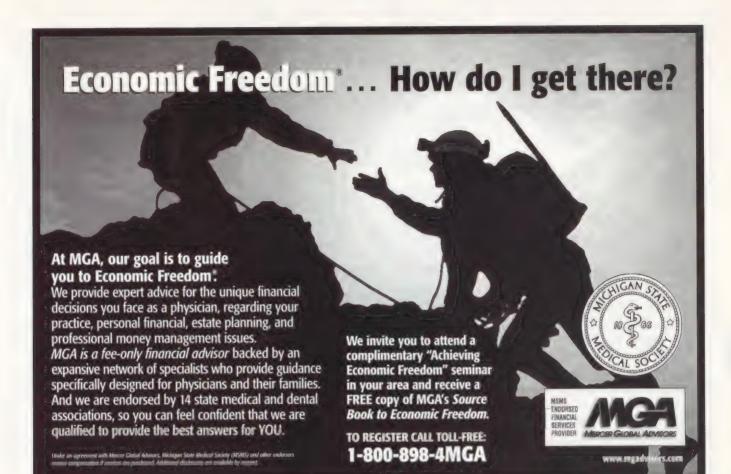
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For more information, call (517) 336-5784.

Send this entire page with your payment. Confirmation of your reservation will be sent to you.





MICHIGAN STATE MEDICAL SOCIETY

the Voice of 12,000 Michigan Physicians

Michigan State Medical Society Mackinac Island

CONFERENCE ON **BIOETHICS**

Grand Hotel Mackinac Island

Friday, Saturday and Sunday Sept. 26, 27 & 28, 1997

For more information.

call David Fox at MSMS at 517-336-5731 or email at dkfox@msms.org.

Physician Assisted Suicide

Come discuss the issue of physician assisted suicide with proponent Timothy E. Quill, MD, and opponent Thomas R. Reardon, MD, chair of the AMA Board of Trustees, at the MSMS Mackinac Island Conference on Bioethics. Doctor Raanon Gillon, editor of Medical Ethics in London, will add an international perspective. A panel of

experts also will discuss various end of life issues. Ethical issues in genetic testing will round out the agenda at this conference sponsored by the Blue Cross Blue Shield of Michigan Foundation.



"A leading voice in the assisted death"



Thomas R. Reardon, MD Chair, American Medical Association Board of Trustees

Timothy E. Quill, MD controversy over physician

Come join the dialogue.

Financial Planning: Achieving Economic Freedom

By: Ralph Ujano, Jr., CFP, CPA

Financial planning quickly is becoming a bandwagon that many firms in the securities, insurance, and banking industries are trying to jump on. Many of these companies are claiming to offer "comprehensive" services. "Comprehensive" has many meanings, as evidenced by the multitude of offerings in the marketplace and the varying skills of the "financial planners" who promote them. What should you be looking for when evaluating a financial planning relationship?

First and foremost is the process used by the financial service provider to develop your financial gameplan. The Certified Financial Planner Board, which regulates licensed Certified Financial Planners (CFPs), has approved the following six-step process:

- (1) Establish and define the clientplanner relationship.
- (2) Gather client data, including goals.
- (3) Analyze and evaluate the client's financial status.
- (4) Develop and present financial planning recommendations and/or alternatives.
- (5) Implement the financial planning recommendations.
- (6) Monitor the financial planning recommendations.

Of special note is step number four. Most financial service providers do not offer much in the area of "alternatives" within their recommendations. Traditionally, they will have a

specific product to sell, which limits the appropriate matching of client goals with the best vehicle to accomplish those goals. For example—if you want to buy a car and you go to a Ford dealer, they will attempt to sell you a Ford, even if it does not meet all of your needs. When considering a financial planner, make sure that they are fee-only, and that they are not trying to sell you products.

Furthermore, you should evaluate the financial service provider's coverage of topical areas within this sixstep process. The scope of a comprehensive financial game plan generally should include the following topics:

- · Wealth Management
- Retirement Planning
- Risk Management
- Estate Planning
- Tax Planning
- Retirement Plans

Another priority should be to evaluate your financial service provider's commitment to assist you in achieving your specific goals and objectives as they are defined by you, not by what fits their needs.

At Mercer Global Advisors, we refer to this vital step as the client's vision of achieving economic freedom. "Economic freedom" means different things to different people—your financial gameplan should center around your own specific definition of what it means to you (for example-knowing that you can retire when you want to, or that you can provide for your children's education, etc.). Your financial service provider should be able to help you identify your goals and define a process for consistently reviewing them, thus enabling you to maintain a clear focus as you strive to achieve your vision.

The vision step is extremely important for spouses to go through together. When you meet with your financial planner for the first time, make sure that you and your spouse both attend that meeting. We have found that "spousal alignment" is the most essential factor in a client's ability to implement the financial gameplan after leaving our office. While most couples are not in total alignment when they come to us for their initial training, they always leave with a better understanding of each other's goals and a mutual commitment to achieve their newly shared vision of economic freedom.

Ask your financial service provider if they are is committed to providing you and your spouse with a custom-tailored, comprehensive financial gameplan that starts with your vision and ends with a written plan to help you achieve economic freedom. If you are not satisfied with their answer, call Mercer Global Advisors today!

Ralph Ujano, Jr. is the director of Client Services for Mercer Global Advisors (MGA).

MSMS endorses Mercer Global Advisors (MGA) to provide elite financial and investment services to its members. The centerpiece of this endorsement is the MGA Economic Freedom Program, a comprehensive financial planning program that has helped thousands of physicrans and their spouses achieve the peace-of-mind that comes from knowing that they are on track to achieving economic freedom.

Institute Promotes World-Wide Community Service

Hillsdale County Medical Society hosts guest humanitarian speaker

By Tom M. Seely

Community service has been and continues to be very important to those in need, especially with medical assistance. That is the mission of the Albert Schweitzer Institute for the Humanities (ASIH) of Wallingford, CT. The Institute was the subject of the Hillsdale County Medical Society's June 24, 1997 meeting.

The Institute was founded in 1990 by Harold E. Robles, PhD, a native of the Netherlands, who first met Albert Schweitzer when Doctor Robles was eight years old. Doctor Schweitzer's influence rubbed off on Doctor Robles, who carried out Schweitzer's humanitarian legacy with the help of Rhena Schweitzer Miller, Doctor Schweitzer's

daughter.

Doctor Robles made a special visit to speak to the Hillsdale County Medical Society (HCMS) at the invitation of his sister-in-law, HCMS President Andrea D. Gelzer, MD. He shared some of his experiences helping people in developing countries and some of

the things that Albert Schweitzer had taught him: commitment to health care and medical relief.

"As founder and president of the Albert Schweitzer Institute for the



Harold Robles, MD, (left), and Andrea Gelzer, MD, (right) at the Hillsdale County Medical Society Meeting June 24, 1997.

Humanities, I have devoted most of my life trying to put into action the teachings of a man who spent 50

"As founder and president of the Albert Schweitzer Institute for the Humanities, I have devoted most of my life trying to put into action the teachings of a man who spent 50 years of his life practicing what he called 'reverence for life.'"

Harold E. Robles, PhD

years of his life practicing what he called 'reverence for life,'" said Doctor Robles.

He added, "What is needed for the business communities today is what is needed for the physician, the scientist, the humanist, the artist... a word-view that allows for hope, for action, for self-fulfillment, without consuming egotism. Thousands practice 'reverence for life' every day and go unrecognized. But their outlook on life multiplies a thousand fold."

Doctor Robles also talked about a program tied in with the ASIH called REMEDY, Recovered Medical Equipment for the Developing World. This not-for-profit organization is dedicated to the dissemination of its medical supply recovery system from hospitals in the United States and Canada for the benefit of hospitals in the developing world.

> The service is free to hospitals and international aid charities. Currently, 60 hospitals throughout the United States are involved in this program.

He ended his talk to the attending physicians in Hillsdale by saying, "Reverence for life is, to me, the fundamental principle of humanitarian law as we

approach the 21st century."

The author is Chief of Physician Outreach Programs.

What's happening in your neck of the woods?

Michigan Medicine would like to develop and expand this monthly feature to include news from across the state. That includes county medical societies, specialty medical societies, physician organizations, business coalitions and other organized groups involving physicians. Send your news by mail, fax, e-mail or phone to Tom Seely, chief of physician outreach programs, P.O. Box 950, East Lansing, MI 48826-0950; fax (517) 337-3490; e-mail tseely@msms.org; or phone (517) 336-5770. Photos in either black and white or color are accepted and will be run on a space available basis.

E D U C A T I O N A L O P P O R T U N I T I E S

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credit toward meeting the requirements of Michigan Law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below of programs that carry at least three hours of Category I credit includes a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

September

2, 9, Bar-Levay Educational Association Ongoing Seminar Series "Re-examining Fundamentals: The Individual Psychotherapy Session." Contact: Lester Potempa, DO, Bar-Levav Educational Association, Location: 3000 Town Center, Suite 1275, Southfield, MI 48075, Phone (810)353-5333. No registration fee. Approved for: 6 Category 1 credits

4-5, Neurological and Behavioral Problems in the Elderly. Location: Towslev Center, University of Michigan, Ann Arbor, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, Michigan, 48106-1157, Phone (313) 763-1400. Approved for: 13.5 Category 1 credits.

5-6, Orthotics & Prosthetics Symposium - A Multidisciplinary Approach to Orthotic and Prosthetic Management, Location: Leighton Auditorium, Siebens Medical Education Building, Mayo Foundation, Rochester, Minnesota. Contact: Registrars, Mayo Foundation, 200 First St. S.W., Rochester, MN 55905. Phone: (800) 323-2688. Fax: (507) 284-0532. Approved for: 14 Category 1 credits. Registration Fee: \$300

9-10, Advances in CT/MRI. Location: Towsley Center, University of Michigan, Ann Arbor, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, Michigan, 48106-1157, Phone (313) 736-1400. Approved for: 15 Category 1 credits.

13, Baby Boomers Coming of Age - That is Menopause. Location: The Ritz Carlton, Dearborn, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 7 Category 1 credits. Registration Fee: \$60

16, 23, Bar-Levay Educational Association Ongoing Seminar Series "Working with the Narcissistic Patient in Group Psychotherapy." Contact: Lester Potempa, DO, Bar-Levav Educational Association, Location: 3000 Town Center, Suite 1275, Southfield, MI 48075, Phone (810)353-5333. No registration fee. Approved for: 4 Category 1 credits.

24-25, The 8th Workshop Course in Office Procedures for Primary Care Physicians. Location: Towsley Center, University of Michigan, Ann Arbor, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, Michigan, 48106-1157, Phone (313) 736-1400. Approved for: 16 Category 1 credits.

26, Cancer Patient Education in the New Millennium. Location: The Atheneum Hotel, Detroit, MI. Contact: Barbara Ann Karmanos Cancer Institute. KARMANOS. Approved for: to be announced. Registration fee: \$75

26-27, The Dearborn Summit: Reducing Costs and Improving Performance in Cardiovascular Care-Practical Lessons. Location: Dearborn Inn, Dearborn, MI. Contact: Registration Secretary, Extramural Programs Dept., American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20814-1699. Phone: (800) 253-4636, Ext. 695. Fax: (301) 897-5400. Approved for: 11.5 Category 1 credits.

30-Oct 7, OHEP/WSU Advances in Surgical Techniques Courses. Location: Wayne State University School of Medicine, Scott Hall, Detroit, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: credits vary. Registration Fee: costs vary.

30, Oct 7, Bar-Levav Educational Association Ongoing Seminar Series "Re-examining Fundamentals: The Individual Psychotherapy Session." Contact: Lester Potempa, DO, Bar-Levav Educational Association, Location: 3000 Town Center, Suite 1275, Southfield, MI 48075, Phone (810)353-5333. No registration fee. Approved for: 4 Category 1 credits.

October

- 3-5, Michigan Chapter of the American College of Cardiology Ninth Annual Conference: Location: Shanty Creek, Bellaire, MI Contact: Alice Betz (517) 663-6622. Approved for: 10 Category 1 credits. Registration fee: \$150.00.
- 8, Primary Pain Management: Solutions for Your Chronic Pain Problems. Location: The Fairlane Club, Dearborn, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 8 Category 1 credits. Registration Fee: \$75
- 9, Long Term Care: Changing Times/Changing Directions. Location: The Management Education Center, Troy, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 6 Category 1 credits. Registration Fee: \$95
- 14, 21, Bar-Levav Educational Association Ongoing Seminar Series "What To Do When Religious and Other Beliefs are Used As a Pathologic Resistance." Contact: Lester Potempa, DO, Bar-Levav Educational Association, Location: 3000 Town Center, Suite 1275, Southfield, MI 48075, Phone (810)353-5333. No registration fee. Approved for: 4 Category 1 credits.
- 25, Nov. 4 Bar-Levav Educational Association Ongoing Seminar Series "Re-examining Fundamentals: The Apprenticeship Model in Training Psychotherapists." Con-

tact: Lester Potempa, DO, Bar-Levay Educational Association, Location: 3000 Town Center, Suite 1275, Southfield, MI 48075, Phone (810)353-5333. No registration fee. Approved for: 4 Category 1 credits.

26-30, 7th World Congress on Ultrasound in Obstetrics and Gynecology. Location: Sheraton Washington Hotel, Washington DC. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 31 Category 1 credits, 25 ACOG Cognates. Registration Fee: Pre-Congress \$175: Congress \$595.

27-29, Clinical Reviews 1997. Location: Leighton Auditorium, Siebens Building, Mayo Foundation, Rochester, MN. Contact: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First St. S.W., Rochester, MN 55905; (800)323-2688; FAX (507)284-0532. Approved for: 22 Category 1 credits. Registration fee: \$325.00.

29, Care of the Terminally Ill Patient in the Primary Care Setting. Location: Towsley Center, University of Michigan, Ann Arbor, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, Michigan, 48106-1157, Phone (313) 736-1400. Approved for: 6 Category 1 credits.

November

12, Endocrinology Review Course. Location: The Fairlane Club, Dearborn, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 5.5 Category 1 credits. Registration Fee: \$80

13-15, Mayo Clinic OB/GYN Clinical Reviews. Location: Mayo Foundation, Rochester, Minnesota. Contact: Registrars, Mayo Foundation, 200 First St. S.W., Rochester, MN 55905. Phone: (800) 323-2688. Fax: (507) 284-0532. Approved for: 16 Category 1 credits, 16 AAFP Prescribed Hours, 16 ACOG Cognates. Registration Fee: \$350.

22, Hepatitis C Video Conference. Location: 1.000 local satellite sites through the Public Health Training Network. Contact: Hepatitis Foundation International, 30 Sunrise Terrace, Cedar Grove, NI 07009. Phone: (800) 232-3299. Approved for: 2.5 Category 1 credits, 2.5 AAFP Prescribed Hours. Registration Fee: \$25.

PEOPLE IN THE NEWS



Michael S. Benninger, MD. was appointed to the Residency Review Committee of the Accreditation Council for

Graduate Medical Education. Doctor Benninger, a West Bloomfield Otolaryngologist and chair of Otolaryngology at Henry Ford Hospital, will be instrumental in revising the accreditation process for medical residency programs and will help determine whether individual programs meet the established standards. MSMS nominated Doctor Benninger for the RRC position.



Douglas Weaver, MD, is a recent recipient of the 1997 Northwest Cardiovascular Award for Excellence from the

American Heart Association. He was honored for his outstanding contributions in cardiovascular research and clinical cardiology. Doctor Weaver is division head of Cardiovascular Medicine and co-director of the Heart and Vascular Institute at Henry Ford Health System. His internationally respected research focuses on pre-hospital resuscitation, defibrillation and severe heart attacks.



G. John Wiegenstein, MD, is new vice president of Occupational Health for ECI, **Emergency Con**sultants, Inc.,

Traverse City. Doctor Wiegenstein is a senior board member for the American Board of Emergency Physicians and Professor of Emergency Medicine at Michigan State University. In his new role at ECI, Doctor Wiegenstein will be working with ECI clients to develop or improve their occupational health clinics and programs.

Eduardo Phillips, MD, of the Department of Medical Affairs, Sinai Hospital, is a new member of the Detroit Medical Center Board of Trustees. The Detroit Medical Center is a non-profit academic health care system that operates eight hospitals (Children's Hospital of Michigan, Detroit Receiving, Grace, Harper, Huron Valley, Hutzel, Rehabilitation Institute of Michigan, and Sinai), two skilled nursing homes and 80 outpatient centers in southeast Michigan.



Thomas J. Zuber, MD, is new Program Director in Family Medicine at Saginaw Cooperative Hospital, Inc. Dr. Zuber,

who is board certified in family medicine with an additional certificate in

geriatrics, also serves as president of the Midland County Medical Society. He is a member of the board of directors for the Michigan Academy of Family Physicians, and teaches for the American Academy of Family Physicians.

Joel Kupersmith, MD, chair of the Department of Medicine in the College of Human Medicine at Michigan State University, has been appointed Dean and Vice President for Clinical Affairs of Texas Tech University School of Medicine in Lubbock. Throughout his tenure with the College of Human Medicine at MSU, Doctor Kupersmith was an integral component in building community networks for health services research and issues related to cost effectiveness of care.

The 3,000-member American Society for Laser Medicine and Surgery has elected Bryan Shumaker, MD, Detroit. president. Doctor Shumaker is director of Laser, Science and Research at St. John Hospital and Medical Center. He has published numerous articles and gained national attention for research involving use of photodynamic therapy in the treatment of bladder cancer. He also is a urologist and member of the Michigan Institute of Urology.

Joseph C. Cerny, MD, of Detroit is the 1997 National Kidney Foundation of Michigan "Champion of Hope." Doctor Cerney is chair emeritus of the urology department at Henry Ford Hospital and clinical

MICHIGAN STATE MEDICAL SOCIETY NEWS

for IMGs, OMSs, Young Physicians and Medical Students

Welcome to MSMS Section News, highlighting activities and topics of interest to International Medical Graduates, Organized Medical Staff members, Young Physicians and Medical Students. It details the priorities addressed by your peers, and alerts you to important emerging issues.

Look for this newsletter three times a year in Michigan Medicine, and find regular updates about MSMS Sections online at http://www.msms.org/ Your comments and suggestions are welcome.

INTERNATIONAL MEDICAL GRADUATES

Amitabha Banerjee, MD, Chair

English Language Training Proposal Approved:

Implementation and Promotion Next on Agenda

An English language training program for physicians, as recommended by the MSMS Section for International Medical Graduates (IMG), has been approved by the MSMS Board of Directors. MSMS voted to sponsor the development of a statewide program for English language training of physicians in order to: (1) further enhance the quality of medical care offered to the citizens of Michigan; (2) provide an approved program to physicians who wish to enhance their training or practice opportunities; (3) offer an MSMSapproved resource to the Medical Licensing Authorities of Michigan pursuing their responsibilities under Public Acts 79 and 80, of 1993.

Who May Participate?

 Residents in training who may be directed into group training at their own request or by program directors;

2 Physicians applying for residency training and those already established in practice who may feel that training would improve their opportunities;

3 Individual physicians already in practice referred by licensing authorities who may require intensive full-time courses at an identified

educational institution.

Background

In 1993, the Governing Council of the IMG Section was charged with investigating establishment of an MSMS "accent reduction" program for IMGs. The alternative would have been legislation that would have resulted in IMGs being singled out to take an oral English test. As Busharat Ahmad, MD, stated, "instead of legislating tests and barring IMGs from the practice of medicine in our state, let us identify those individuals and help them with accent reduction and education with English language training courses. Legislation is not the answer; education and understanding is."

Goals

Accuracy and fluency are the main goals of the English language course. Students also will study the problems that arise related to the understanding of spoken language. The class will meet for 1.5 hours, twice a week, with one-on-one tutorials scheduled (one hour per student). The cost will be \$1,000 per enrollee (paid for by each enrollee) for a 15-week course, with a minimum of 10 enrollees, and a maximum of 15.

The course is coordinated by Michigan State University. For details contact Andy Lott at MSMS at (517) 336-7589.

Busharat Ahmad, MD Elected Chair of New AMA/ IMG Governing Council



Busharat Ahmad, MD, Michigan's appointed representative to the AMA/IMG Governing Council, was elected the first Chair of the AMA/IMG Section, which met July 18-20 in Chicago. Congratulations Doctor Ahmad!

"Speaking for all IMGs, I express our appreciation for your confidence and pledge our support for the aims, the goals, and the mission of the American Medical Association. We also once again pledge to increase membership in the AMA among our IMG constituency." — Busharat Ahmad, MD

For questions or more information about the MSMS International Medical Graduates Section, please contact Andrew J. Lott at (517) 336-7589, or at alott@msms.org.

MEDICAL STUDENTS

VICE CHAIR OF MEDICAL STUDENT SECTION TO COMPLETE EXTERNSHIP ROTATION IN ATHENS, GREECE

Param Dedhia, Vice Chair, will be spending four weeks doing rotations with various specialists in the Department of Surgery at the private hospital of Hygenia in Athens, Greece. Param also plans to spend time with some of the physicians and administrators to better understand the Greek health care system.

MEDICAL STUDENTS DO MAKE A DIFFERENCE!

While at the AMA Medical Student Section Annual Meeting in June, medical student delegates from the three medical schools in Michigan collected \$300 in contributions towards relief efforts for the North Dakota Medical School. The medical school was devastated from the floods the past spring and all medical students were asked to donate. Michigan schools collected funds on the spot and

challenged the Michigan Delegation to the AMA to support this cause as well. Leading the efforts were Peter Watson and Raj Patel from WSU; Christine Maser and Param Dedhia from MSU; and Shabai Ansari-Ali from U of M.

For questions or more information about the MSMS Medical Student Section, please contact Andrew J. Lott at (517) 336-7589, or at alott@msms.org.

Charlene An, Chair

MSMS MEDICAL STUDENT SECTION

1997-98 MSMS Medical Student Section Governing Council

Chair - Charlene An (University of Michigan)

Vice Chair - Param Dedhia (Michigan State University)

Secretary - Amy Osborn (Michigan State University)

Delegate - Laura Uthoff (Michigan State University)

Delegate - Jerry Mastaw (University of Michigan) Delegate - Joel Mendelin (Wayne State University)

Alternate Delegate - Christina Maser (Michigan State University)

Alternate Delegate - Shaiba Ansari-Ali (University of Michigan) Alternate Delegate - Pramad Sanghi (Wayne State University)

Delegate to the AMA - Peter Watson (Wayne State University)

Legislative Chair - Robert Cambray (Michigan State University)

Women's Issues - Kirsten Stoesser (University of Michigan) Laura Uthoff (Michigan State University)

International Health Issues - Pramad Sanghi (Wayne State University)

DRGANIZED MEDICAL STAFF

The MSMS Organized Medical Staff Section reviewed 32 resolutions and 10 reports at the 29th AMA/ OMSS Assembly, June 20-21 in Chicago. The Michigan Delegation presented testimony to such topics as:

- Emergency Treatment and Active Labor Act
- Preservation of Opportunities for U.S. Graduates and International Medical Graduates already legally present in the United States
- Status Reports on Health Maintenance Organization Profiles on the Internet
- Managed Care Eligibility
- National Committee on Quality Assurance
- Opposing the Substitution of Licensed Physicians with Nurse Practitioners

- Managed Care Companies and the Practice of Medicine without a License/Liability of Managed Care Entities as Their Employees, Agents, Ostensible Agents and Representatives
- Medical Staff Role in American Medical Accreditation Program (AMAP)
- The Impact of Decreasing Reimbursement for Medical Services on Patient Care Access and Quality
- Unilateral Imposition of Medical Staff Development Plans and Economic Credentialing Controlled by the Hospital

The OMSS Delegates participated in "Performance Review and Managed Care" that included a series of halfhour presentations:

Overview of HEDIS 3.0: A Na-

Edward J. Rutkowski, MD, Chair

tional Perspective

The Implementation of HEDIS 3.0: Commercial and Government Sponsored Reviews

Preparing for an Onsite Review: American Medical Accreditation Program: Details and Staging of Review Process

The doctors also participated in a second education program "Advocating Your Issues At Home" where the subjects discussed were:

- All Politics Are Local
- What Elected Officials Care About
- Developing Your Message
- Communicating Your Message

Delegates heard a keynote address, "Adapt or Perish" presented by David Gorden, CSP, CPAE, Disney, Inc. They also attended the Washington update by Scott Wilber, Director, Congressional Affairs, Washington D.C.

For questions or more information about the MSMS Organized Medical Staff Section, please contact Tom Plasman at (517) 336-5724, or at tplasman@msms.org/

MSMS ORGANIZED MEDICAL STAFF SECTION

1997-98 MSMS Organized Medical Staff Section Governing Council

Chair - Edward J. Rutkowski, MD

Vice Chair - John H. McLaughlin, MD

Secretary - John G. Wiegenstein, MD

Member At-Large - Robert G. Borchak, MD

Member At-Large - Arnold M. Cohn, MD

Delegate - John A. Rupke, MD

Alternate Delegate - Hassan Amirikia, MD



From left to right; Doctors Cohn, Rutkowski (chair), Wiegenstein and McLaughlin at the Joint Section Meeting.

Young Physician

SECTION

The 9th Meeting of the MSMS Young Physician Section (YPS) met on March 1, 1997 at the Ritz Carlton in Dearborn. Presiding over the meeting was Chair, Gregory L. Walker, MD, an emergency room physician from East Lansing.

The section debated nine resolutions of which eight were adopted as amended and then forwarded to the MSMS House of Delegates for action. Of the eight debated at the MSMS House of Delegates, six were adopted as amended and no action was taken on two of the issues.

The section proposed resolutions on the following topics: practice management; a newsletter for the section; tax deductions for those who provide indigent care; the study of alternative medicine; support for prudent layperson legislation; and policy on insurance company denials.

The YPS Governing Council will monitor these issues closely and provide any updates on the issues.

Pino D. Colone, MD, also attended the recent meeting of the AMA Young Physician Section in Chicago. The AMA-YPS debated 36 resolutions of which three were forwarded immediately to the AMA House of Delegates for action at the annual meeting, 17 will be presented at the AMA House of Delegates Interim meeting, 10 were internal matters for the AMA-YPS Governing Council and six were not recommended for further action. For information regarding the AMA-YPS resolutions please contact Jon Burkhart at the AMA Department of Young Physician Services, (800) 262-3211.

The Young Physician Section Governing Council will be meeting in September. If you are interested in additional information regarding the YPS please contact MSMS staff, Deborah Zannoth, (517) 336-5763 or at dzannoth@msms.org/



Pino D. Colone, MD, Chair

Pino D. Colone, MD, Chair, MSMS Young Physician Section, enjoys the lively debate during the YPS Annual Meeting.

MSMS Young Physician Section

1997-98 MSMS Young Physician Section Governing Council

Chair - Pino D. Colone, MD

Chair Elect - David Nadeau, MD

Member At-Large - Kevin Loker, MD

Member At-Large - Timothy Cox, MD

Delegate - Peter S. Chang, MD

Alternate Delegate - David E. Randolph, MD

Immediate Past Chair - Gregory L. Walker, MD

SECTION

Michigan residents have been making their presence known at the local, state and national levels this year. The MSMS Resident Physicians Section (MSMS-RPS) continues to be a place for physicians in training to learn about organized medicine, advocate on behalf of their patients and develop leadership skills.

Participation in the MSMS House of Delegates and the AMA Resident Physicians Section annual and interim meetings has been steadily increasing, with Michigan residents submitting and testifying on resolutions, serving on reference committees, and participating in regional and specialty caucuses

Chair Anthony Bennett, MD, received an AMA Policy Promotion Grant to support a Detroit domestic violence shelter. The grant has allowed the shelter to offer family outings for women and their children who have received services. Other grant applications are in the works.

Doctor Bennett and Dheeraj K. Rajan, MD, attended the AMPAC Campaign School, an intensive week of training on participating and running political campaigns. Partha S. Nandi, MD, immediate past-chair of the section, served on the Michigan delegation to the AMA annual meeting in Chicago. His efforts in analyzing and testifying on issues before the reference committees was lauded by delegation chair Billy Ben Baumann, MD.

The depth of leadership talent in the section is evident in the number of current and past Governing Council members that have been awarded the AMA/Glaxo Wellcome Achievement Award, which recognizes leadership in organized medicine or community activities. Past recipients include current chair Anthony A. Bennett, MD; immediate past chair Partha S. Nandi, MD; former treasurer Harsha P. Jayatilake, MD; and at large members Charles M. Boyd, MD, and Kurt O. Doggwiler, MD.

The MSMS-RPS has had its own web page (http://msms.org/rps) for two years, and it recently has been

updated to include more information on section activities and an on-line application. With the newly elected governing council and recent participation at the AMA meeting, new updates will be forthcoming on the web. Governing Council members include: Chair: Anthony A. Bennett, MD Vice Chair: Lynn Chen, MD Secretary: Neeraj Chepuri, MD

Treasurer: Baljit S. Deol, MD

MSMS Delegate: Andrew Jeffers, MD

AMA Alternate Delegate: Partha S.

Nandi, MD

Members At Large: Dheeraj Rajan, MD Charles M. Boyd, MD

For questions or more information about the Resident Physician Program please contact Julie Lester at (517) 336-5768 or via e-mail, jlester@msms.org/



Partha Nandi, MD, right, participated in the Michigan delegation briefings at the AMA Annual Meeting in Chicago.

Michigan delegation chair Billy Ben Baumann, MD, commended Doctor Nandi's participation on behalf of the Resident Physicians Section. Doctor Nandi served as the alternate delegate to the AMA.





Anthony Bennett, MD, chair of the MSMS Resident Physicians Section, presents a check that will support family outings for My Sister's Place, a Detroit domestic violence shelter.

professor of urology at the University of Michigan. He is past NKFM board of trustees president and has served the state and national kidney foundations for more than 20 years.

Edward Coffey, MD, has begun a three-year term on the American Neuropsychiatric Association board of directors. Doctor Coffey is chair of the Henry Ford Health System Department of Psychiatry and Vice President of behavioral sciences. He supervises psychiatry, psychology and neuropsychology services, in addition to the Henry Ford Sleep Disorders and Research Center. Hospital and Kingswood Maplegrove Centers for Chemical Dependency.

Mary Elizabeth Roth, MD, is a recent recipient of the Robert R. Allen Symbol of HOPE (Helping Other People through Empowerment) award from the American Journal of Health Promotion. She was honored for holding free health education classes in churches and drug halfway houses, and for producing a television program for seniors called, "To Your Health." Doctor Roth is chair of the Family Practice department at Providence Hospital and Medical Centers.

Allen S. Lichter, MD, is the new president of the American Cancer Society of Clinical Oncology. He is professor and chair of the Radiation Oncology department at the University of Michigan Comprehensive Cancer Center and is co-author of the textbook Clinical Oncology.

"Heart and Soul" magazine has named Stephanie Lucas, MD, Detroit, one of the nation's top 25 African-American female physicians. Doctor Lucas is an endocrinologist at St. John Hospital and Medical Center. She was honored for her focus on prevention, for empowering her patients, serving the community and respecting natural remedies.

George L. Bluhm, MD, Southfield, has been awarded the Maimonides Award of the State of Israel Bonds Professional Health Services Division. Doctor Blum has been honored for notable leadership and outstanding participation in community services and for forging connections with the State of Israel. He is a member of the MSMS Liaison Committee with Third Party Payers and is immediate past president of the Michigan Chapter, American Academy of Pediatrics.

Warren Brandes, DO, Madison Heights, is a new appointee to the Board of the National Institutes of Health. Doctor Brandes is assistant clinical professor of the College of Osteopathic Medicine at Michigan State University and is editor of the Journal of the American Osteopathic College of Ophthalmology and Otolaryngology. He is on the staff at Oakland, Mt. Clemens and Botsford general hospitals, as well as at Bon Secours, Huron Valley and Bi-County hospitals.

Saul Gorne, MD, Flint, recently received the Clement A. Alfred Humanitarian Award from the Community Foundation of Greater Flint. The award recognizes health professionals for outstanding dedication and concern for their community. Doctor Gorne was in private practice in Flint from 1935-1985, and volunteered for the United Way, Flint Jewish Federation, Jewish Family and Children's Services, Planned Parenthood, Hospice for Communities and local, state and national medical societies.

OBITUARIES

Albert I. Tactac, MD, died on November 16, 1996. He was 70. A Livonia urologist who graduated from the French Faculty of Medicine in Beirut, Doctor Tactac was a member of the Wayne County Medical Society, MSMS and the AMA.

The 1975-76 Calhoun County Medical Society President, Anne F. Norgan, MD, died in December 1996. She was 77. A psychiatrist from Battle Creek, Doctor Norgan graduated form Rupert - Carl University in Heidelburg, Germany. She was a member of the American Psychiatric Association, and MSMS.

Arthur L. Foley II, MD, died December 12, 1996. He was 82. Doctor Foley was an Air Force flight surgeon in Europe from 1942-46, a graduate of the University of Michigan Medical School and an anatomy professor. He was a member of the Washtenaw County Medical Society, former president of the Tri-county Medical Society and served on the MSMS Maternal Health Committee.

Thomas N. Cross, MD, died December 13, 1996. He was 77. An Ann Arbor psychiatrist who graduated from Columbia College of Physicians and Surgeons, Doctor Cross was a member of the Michigan Psychiatric Society, Ann Arbor Psychiatric Association, MSMS and American Psychiatric Association.

L. William Vergith, MD, died December 27, 1996. He was 73. Doctor Vergith, a graduate of the University of Lausanne in Switzerland, was a radiologist in Flint. He was a member of the Genesse County Medical Society, MSMS and the AMA.

James R. Reif, MD, died in February 1997. He was 65. A Midland obstetrician and gynecologist, Doctor Reif graduated from the University of Michigan Medical School. He was a member of MSMS and the AMA.

Hugh O. Thompson, MD, a general practitioner from Gaylord, died February 12,1997. He was 89. Doctor Thompson, a graduate of Wayne State University Medical School, volunteered his time and experience as the medical director at the Hospice of the North Inc, as well as the American Heart Association, the Commission on Aging and the Red Cross Blood Bank. He was a member of Wavne County Medical Society and MSMS.

Donald J. Litzenberg, MD, died in February 1997. He was 71. A Wyandotte general practitioner, Doctor Litzenberg graduated from the University of Toronto Medical School. He was a member of the Wayne State Medical Society and MSMS.

Thomas G. McDonald, MD, died on February 24, 1997. He was 56. A graduate of Wayne State University Medical School, Doctor McDonald practiced general radiology and nuclear medicine in Detroit. He was a member of the Wayne County Medical Society, MSMS and the AMA.

Galvin E. Schorer, MD, died on March 18, 1997. He was 78. A Detroit psychiatrist, Doctor Schorer graduated from the University of Wisconsin Medical School. He served as chair of the Wayne County Medical Society Mediation Committee, and was a member MSMS and the American Psychiatric Society.

Detroit internist Otto H. Hahne, MD, died March 23, 1997. He was 79. A graduate of Keil University in West Germany, Doctor Hahne was a member of the American Thoracic Society, Wayne County Medical Society and MSMS.

James S. Todd, MD, surgeon ethicist, visionary and former Executive Vice President of the American Medical Association, died June 24, 1997, in New Jersey. He was 65. Doctor Todd successfully directed the AMA though a time of stress and change in the medical profession and did much to securely position the AMA as the leading force of medicine on the eve of the 21st century.

Doctor Todd, who retired in 1996 after six years as Executive Vice President, passed away just as the



In Memorium: James S. Todd, MD

AMA House of Delegates, celebrating the organization's 150th anniversary, was meeting in Chicago.

Doctor Todd was elected a member of the Board of Trustees in 1980, became Senior Deputy Executive Vice President in 1985 and was named Executive Vice President in 1990. He was a commissioner to the ICAHO from 1982-85.

Doctor Todd was born in 1931, and graduated cum laude from both Harvard College and Harvard Medical School. He interned and served his residency in surgery at Columbia Presbyterian Medical Center in New York City, becoming chief resident in 1963. He was a Diplomat of the American Board of Surgery and a Fellow of the American College of Surgeons. For many years, he was in private practice in northern New lersev.

Disciplinary Actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

MI 48183

Action, Date Taken: Probation - 2 yrs. 6-5-97

Reason: Probation Violation

Name: Malcom K. Johnston, DO, 207 E. Bellevue, Box 475, Leslie, MI 49251

Action, Date Taken: Limited License, Probation - 1 yr., 6-5-97

Reason: Drug Related

Name: Michael E. Zevitz, MD, 325 East H Street, Iron Mountain, MI 49801

Action, Date Taken: License Suspended - 30 days, Upon reinstatement, probation - 1 yr., Fine - \$3,000.00, 6-20-

Reason: Unprofessional Conduct, Lack of Good Moral Character

Name: Ratnakar Kini, MD, 5690 Forman Drive, Bloomfield Hills, MI 48301

Action, Date Taken: Voluntary Surrender of License, 5-21-97

Reason: Mental/Physical Inability to Practice

Name: Eric S. Waugh, MD, 16204 Ohio, Detroit, MI

Action, Date Taken: License Suspended - 6 mo. & 1

Reason: Failure to Report/Comply Sister State Disciplinary Action

Name: John E. Blanzy, DO, 14319 Dix, Southgate, MI

Action, Date Taken: License Limited - minimum 1 yr., Probation - 1 yr., Fine - \$5,000.00, 6-1-97

Reason: Negligence/Incompetence

Name: Jack Kevorkian, MD, 223 S. Main St. #1, Royal Oak, MI 48067

Action, Date Taken: Cease and Desist, 4-4-97

Reason: Technical Violations of the Public Health Code

Name: David W. Law, DO, 2128 W. Jefferson, Trenton, Name: Howard P. Levy, DO, 42855 Garfield, Suite 105, Clinton Township, MI 48038

> Action, Date Taken: The Order Staying Discipline issued by the Wayne County Circuit Court on 11-12-96 remains in effect. The Superseding Final Order of the Board dated 2-26-97 and effective 3-28-97 is stayed.

> Name: Franz W. Jordan, MD, 2244 South Reese Rd., Reese, MI 48757

> Action, Date Taken: License Suspended - 6 mo. & 1 day, Fine - \$10,000.00, 5-21-97

Reason: Drug Related

Name: James H. Dallman, MD, 1675 Leahy St., Muskegon, MI 49442

Action, Date Taken: License Revoked, Fine \$25,000, Community Service, 4-28-97

Reason: Negligence/Incompetence, Lack of Good Moral Character

Name: David L. Thomson, MD, 7924 Woodingham, West Bloomfield, MI 48322

Action, Date Taken: Reinstatement Denied, 4-22-97

Name: Audberto C. Antonini, MD, 1611 Monroe, Dearborn, MI 48124

Action, Date Taken: Reprimand, Fine - \$250.00, 5-16-97 Reason: Incompetence

Name: Samuel M. Sefton, MD, 2259 Idlewild, Richland,

Action, Date Taken: Reinstated w/Probation - 1 yr. 4-14-97

Name: Usha Sudindranath, MD, 18181 Oakwood Blvd. Suite 331, Dearborn, MI 48124

Action, Date Taken: License Suspended - 30 days, Upon reinstatement, probation - 1 yr., Fine \$2000.00, 4-14-97 Reason: Violation of General Duty/Negligence

Name: Robert E. Green, DO, 130 River St., Elk Rapids, MI 49629

Action, Date Taken: License Suspended - 6 mo. & 1 day, Fine \$2,000.00, 5-1-97 Reason: Negligence/Incompetence

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Richard G. Abood, MD, Birmingham J.S. Adams, MD, Franklin Tessy C. Agomuoh, MD, Detroit Rolando M. Beredo, MD, Jackson Steven Borzak, MD, Detroit Maria Y. Cardozo, Farmington Hills Kyle A. Carr, MD, Traverse City Jose Carrera, MD, Grass Lake Benjamin S. Chen, MD, Roseville Robert M. Cleary, MD, Grosse Pte Shores

Elizabeth A. Colaiuta, MD, *Detroit* Christopher J. Conlin, MD, *Pontiac* John L. Cook, MD, *Hope* Tarlika C. Dhabuwala, MD, Clarkston

Venkata Dharbhamulla, MD, Monroe Thomas R. Doerr, MD, Traverse City Christopher L. Eaton, MD, Traverse City

Robert C. Erickson, MD, Birmingham Peter Farkas, MD, Allen Park Shahana Farrukh, MD, Caro Lori Fedoronko, MD, Warren Mark S. Friedland, MD, Detroit Matthew J. Griffin, MD, Livonia Claude W. Hall, MD, Farmington Hills

Julia E. Hall, MD, Muskegon Deborah Hamby, MD, Roseville Barbara A. Hannah, MD, Detroit Dana Hocking, East Lansing
Patrick Hulst, MD, Holland
Ardeshir N. Irani, MD, Waterford
Charlotte A. Johnson, MD, Holland
Donald C. Jones MD, Jackson
Karen N. Klein, MD, Flint
O'Neal W. Koger, MD, Bloomfield
Hills

Ramachandra B. Kolachalam, MD, Southfield

Leslie B. Leicht, MD, Pleasant Lake William E. Leppert, DO, Jackson Douglas L. Long, MD, Kalamazoo Cheryl S. Loubert, MD, Manistee Peter T. McAndrews, DO, Alma Gregory A. Myers, MD, Muskegon Barbara A. O'Malley, MD, Shelby Twb

Melissa H. Olken, MD, Portage Kalpeshkumar K. Panchal, MD, Hillsdale

Vladamir Panine, MD, Birmingham Dennis T. Rafaill, MD, Grosse Pte John E. Raftery, MD, Traverse City Abdul Rauf, MD, Coldwater Sharon Rothstein, MD, Southfield Bharti Sachdev, MD, Jackson Karl W. Schwarz, MD, Birmingham Brent A. Senior, MD, West Bloomfield Ayaz Shaikh, MD, Auburn Hills Scott Silveira, MD, Dearborn Bruce J. Skolnik, MD, Dearborn Timothy H. Soper, MD, Jackson Frank D. Sottile, MD, Pontiac Florence J. Sri-Tharan, MD, Grosse Pte

Sanjeev G. Vaishampayan, MD, Livonia

Jonathan P. Wolff, DO, Eaton Rapids Raymond A. Wood, DO, Marquette George C. Xakellis, MD, Dearborn John J. Zappia, MD, Farmington Hills



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Strategies For Your Practice

MSMS addresses risk management issues

By Mary Anne Ford

his fall's 1997 seminar series offers valuable resources to meet practice and business challenges. Three seminars, each in two locations, will address current topics in regulatory compliance, reimbursement, capitation and quality improvement.

All seminars are three hours long and are \$90 for MSMS, MMGMA and MOA members; \$120 for non-members. For more information, contact Patricia Bokovov at (517) 336-5723.

Physician's Guide to Codina and Documentation

6:00-9:00 p.m.

October 23, Treasure Island, Saginaw October 30, Wayne County Medical Society

True or False? A payment made is a payment kept. (False). A payment made is the correct payment. (Not Always). Informed physicians and staff raise the probability of winning an appeal. (True) Understanding coding and documentation guidelines are important to your practice revenue and to avoiding costly audits and appeals. Under the Health Insurance Portability Act, it is especially important that physicians be involved with maintaining standards for coding and documentation in their practices. This program is designed for physicians, clinical staff responsible for choosing levels of care and managers responsible for implementing office procedures.

The three-hour program will include information on the definitions and documentation guidelines for:

- time
- history
- medical decision making
- prolonged care
- consultations
- preventive care during same visit as a pa-

tient complaint

Other program highlights:

- case examples to illustrate the decision process
- risk management tips
- diagnosis coding guidelines
- modifier situations that physicians need to be aware of
- tools to assist you in implementing a system in your office
- question and answer period

Faculty

MSMS experts on coding, documentation and risk management, including Joyce A. Nurenberg, Certified Procedural Coder and Chief, Reimbursement Ombudsman for MSMS; and Peggy Galloway, RN, MHA, Manager, Risk Management, MSMS

Tools for Quality Improvement

2:00-5:00 p.m.

November 13, Wayne County Medical Society, Detroit

November 20, Western Michigan University Regional Center, Grand Rapids

Registration: \$90

You know that measuring and analyzing the quality of the care that you deliver is vital, but where do you begin? MSMS has asked physician leaders in quality and medical management to share their expertise, and tell you why defining and measuring the process of care will be vital to your future success. This program will be of interest to physicians, nurse managers and group practice administrators. There are two quality-related sessions:

Session I: Establishing a Collaborative Clinical Quality Program

Description

Establishing collaborative quality parameters allows an organization to focus on processes and not on individuals. This can enhance clinical quality and, at the same time, lower costs. This session will show how a team-approach to quality measurement has led to clinical improvements, using endoscopy as a case study.

Faculty

Kathy Wells, RN, is the Manager of Endoscopy at Saint Mary's Health Services in Grand Rapids. She is a former ICU nurse who has presented quality assurance talks at national GI nurses conferences.

Paul O. Farr, MD, is a practicing gastroenterologist. He is a former Chief of Staff and member of the Board of Trustees at Saint Mary's Health Services.

Session 2: Monitoring Physician Performance: Measure, Assess and Improve Description

As physicians begin to organize and adjust to managed care, they must create structures for measuring and reporting physician performance. A good utilization management program allows physicians to manage quality within the group and foster accountability for the care delivered. This session will demonstrate how the organizational structure of a physician group can facilitate successful utilization management and quality improvement.

Faculty

Douglas A. Edema, MD, is a family practitioner and is President/CEO of Advantage Health, an 80-physician primary-care group affiliated with Saint Mary's Health Services in Grand Rapids.

Understanding Capitation

6:00-9:00 p.m.

November 12, Dearborn

November 19, East Lansing

The number of capitated and other risk-sharing agreements is growing in Michigan. This growth will continue as the Michigan Medicaid program continues its effort to enroll most Medicaid patients into a managed care plan, and as more and more Michigan health plans develop Medicare risk programs. This threehour seminar is designed to enhance your understanding how risk sharing arrangements work, and to offer advice on tools you can use to negotiate and monitor capitated payments.

Faculty

Experts from Michigan Medical Advantage, including Bob Kardell, Manager, Capitation and Rate Development and Mark Cascarelli, Managed Care Systems Administrator

To register, contact Patricia Bokovoy at (517) 336-5723 or at pbokovoy@msms.org/

The author is MSMS Director, Medical Economics and Health Care Delivery

Women in Medicine

MSMS profiles female members

By Julie L. Lester

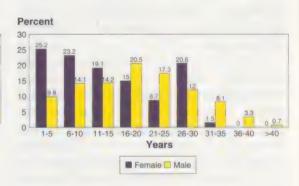
The average woman MSMS member is slightly younger (45) than her male counterpart (50). The age distribution reflects that women are entering organized medicine in greater numbers than in previous years when there were fewer women in medicine. Women physicians are more likely to choose primary care specialties (42.7 percent) than male physicians (29.6 percent) The type of practice is likely influenced by changes that have occurred in the market, as women are less likely to be in solo practice (27.8 percent) and more likely to be employed (42 percent).

Source: MSMS Survey on Practice Characteristics, 1996.

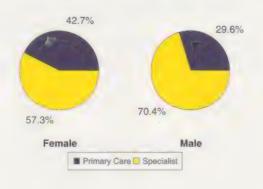
The author is MSMS Manager, Health Care Research

Distribution by Age

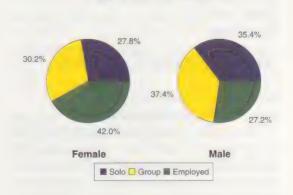
Years in Practice



Focus of Practice



Type of Practice



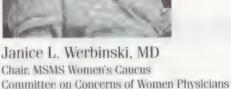
Gone are the days when caring for our patients was done only in an office or hospital. Today caring means working on a national level to preserve patients' rights. It means supporting your local, state and American Medical Associations. Only by working together can we achieve a new day in health care for all patients.

Make a commitment to your patients and your profession. Join the AMA, and your state and county medical associations today.



Kalamazoo

Gynecology





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Michigan Takes a Shot At **Immunization Registry**

By Mary E. S. Jensen

eptember 30, 1997, is the target date to have all of Michigan activated under the new Michigan Childhood Immunization Registry. In 1994, when the Centers for Disease Control reported Michigan had the lowest immunization rates for children under two years of age, the state took steps to increase the percentage of children receiving immunizations. During the past three years, community efforts have raised immunizations rates from 61 percent in 1994 to 74 percent in 1997. Furthermore, legislation was passed in 1996 allowing Michigan to establish a state-wide immunization registry.

This year, the Michigan Childhood Immunization Registry (MCIR) became a reality. On April 1, 1997 in southeastern Michigan, the first of six regional servers was activated allowing the Livingston County Health Department and Child Health Associates in Washtenaw to become the first participants of the MCIR.

Howard Weinblatt, MD, chair, MSMS Task Force on Immunization, and a physician at Child Health Associates has had the opportunity to test and use the Immunization Registry from the project's inception. "This is a wonderful tool to help organize immunization records and not miss opportunities to vaccinate children," said Doctor Weinblatt. "We have worked hard to create a system which will be user-friendly for providers and be productive in increasing Michigan's immunization rates."

"Imagine the day when there are no more immunization requests from schools or daycare centers, no pulling charts, copying or mailing. Imagine being able to answer a parent's question or check a new patient's immunization history at the press of a button. Imagine no more HMOs telling you to pull charts for immunization audits" said Doctor Weinblatt. "The registry will not only improve our ability to immu-

nize our children, but will also streamline and improve some of the most costly and time-consuming chores physicians now face."

Access to the MCIR for input or query is attainable in four ways. Offices or clinics that use PC compatible computers can link to the regional server via modem for submission or retrieval of data. Transfers can be made from existing electronic immunization registries or practice management systems. Phone/fax connections can be made using a touch tone telephone to retrieve data and receive data back by fax. Child

Vaccines Data Forms can be mailed or faxed using official MCIR forms.

Time Savings

"More and more providers are hearing about the immunization registry and realizing the tremendous time savings their practice can experience." said Dan Lafferty, Region 1 Project Director, Southeastern Michigan Childhood Immunization Registry. "The initial time to activate the registry in a provider's practice is recovered several times over in both practice management and patient care functions." There is no fee for provider software, training or manuals. Providers should contact their regional offices for general information, provider user/usage agreements, training and activation.

For further information about the Registry, see a demo online at http://www.msms.org/ or contact Mary Jensen at (517) 336-5706 or mjensen2@msms.org/

The author is MSMS Immunization Communication Liaison

Michigan Childhood Immunization Registry (MCIR) Regions



Region 1

Southeastern Michigan Health Association Contact: Daniel C. Lafferty, MA, MPA, (313) 873-0840

Region 2

Van Buren County Health Department Contact: Nancy Gallert, (616) 621-3143; Kent County Health Department

Contact: Theresa Hoyle, (616) 336-3971

Region 3

Mid-Michigan District Health Department Contact: Beverly Stowell, (517) 831-5203

Region 4

Genesee County Health Department Contact: Mel Trueblood, (810) 257-3194

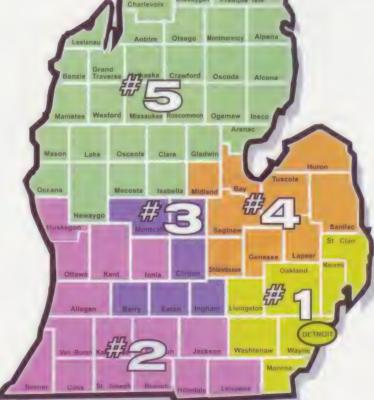
Region 5

Western Michigan Associated Health Departments (District Health Department #5)

Contact: Linda van Gills, MA, (616) 873-2193

Region 6

Delta-Manominee District Health Department Contact: Mary Klimp, MHA, (906) 786-4111



Planning For the Future

Board looks at tough questions and new ideas

By David K. Fox

"I thought that the process was good. We were allowed to hear a wide breadth of ideas. We heard more ideas about how to make membership more meaningful. The process will also allow us to prioritize the larger agenda for the patient."

> John M. MacKeigan, MD

Here are ideas that the MSMS Board developed as a preliminary activity in this year's strategic planning process. During two intense sessions at the Midsummer Board Meeting, strategic planner Michael G. Skinner, PhD, created a friendly competition by dividing the Board into six small groups and asking them to answer the questions listed below. Interestingly, each group came up with fairly similar answers. Doctor Skinner pointed out that all types of associations nation-wide share many of the same problems and opportunities.

The full MSMS Forward Planning Committee will meet on October 29 at MSMS Headquarters during the MSMS Leadership Training and Strategic Planning Day. Invited to join the Board are all county and specialty society presidents and executives, committee chairs, section chairs, several physician organization leaders and a number of HMO medical directors.

You are encouraged to include your input by completing the fax-back survey on page 54 that lists these same questions.

An associations' success depends on member participation. Fax your input today.

These questions are not in any priority order, nor are any of the listings below each question in any priority order.

What are the important concerns MSMS members are facing?

- autonomy/loss of control
- litigation
- · legislation
- education
- scope "creep" from physician expanders
- decreasing reimbursement revenue
- patient relations
- administrative burden
- disunity of profession

What are the major issues facing MSMS?

- member participation
- recruitment & retention of members
- planning and setting priorities
- representing all MDs
- communication
- developing non-dues revenue
- disunity of profession

What is MSMS doing that should be continued?

- legislative activities
- outreach to new members/recruitment
- Michigan Medical Advantage
- non-dues revenue
- education
- communication

What is MSMS not doing that it should be doing?

- more effective interaction with county societies
- better communication and services for rural MDs
- increased public relations activities
- more proactive in introducing legislation
- improve structure of the organization
- use resources to the fullest
- · deal effectively with change

How can MSMS improve member participation?

- develop a mentor program for committees
- ask colleagues to participate
- increase electronic communication
- provide staffing for non-staffed county
- develop grass roots participation
- effective planning
- recognition of membership participation

How can MSMS expand?

- develop more non-dues revenue in insurance programs
- initiate more joint ventures
- increase coalition development and activi-
- make services available to non-members
- improve current services

Which services do MSMS members use

- insurance
- third-party consulting
- networking
- stop-loss program
- legislative advocacy
- education
- legal advice
- practice management
- supplies
- billing

What new services should MSMS offer?

- locum tenens service.
- expand computer department

- credentialing services
- more focused education; i.e., computers, practice management
- staffing for non-staffed county societies
- discount programs

The MSMS Board of Directors worked with strategic planning consultant Michael G. Skinner, PhD, at the Midsummer Board Meeting in July as an exercise in preparation for planning with the full MSMS Forward Planning Committee this fall. Doctor Skinner shared the results of several of his national surveys concerning effective associations. Following is a synopsis of a survey on a common goal and a common problem for all associations, membership participation.

The author is MSMS Director, Public Relations and Federation Planning.

"Doctor Skinner did a superb iob of leading us through a discussion of many of the important issues facing any organization today. Now we must work to best position MSMS to head into the 21st century."

Cathy O. Blight, MD



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Michigan Medicine September 1997 53

Give us your input!

Fax-Back Survey on Strategic Planning

Please take a few minutes to add your input to the MSMS strategic planning process. Results from this member survey will be added to the discussions at the MSMS Leadership Training and Strategic Planning Day on October 29 when the full MSMS Forward Planning Committee will meet to set the agenda for MSMS activities for the next year and beyond.

What are t	the major issues facing MSMS as an organization?
What is M	SMS doing that should be continued?
What is M	SMS not doing that it should be doing?
How can I	MSMS improve member participation?
Which MS	MS services/activities do you utilize most?
What new	services should MSMS offer to members?

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Physicians Plus Spouses Equal a Partnership for Better Health



By Blanche L. Mindlin

I am deeply honored to have the privilege of being your new MSMS Alliance president. After almost a decade of declining membership, our MSMS Alliance has turned the tide and this past year experienced a slight increase in membership.

Membership is the lifeline of our organization. MSMS will work with us to achieve our mutual goal of making MSMS and its Alliance the natural partnership they have always known, representative of 14,000 medical society families helping the citizens of this great state to better health in the coming century.

Our second lifeline is in the area of health promotions. With the AMA Alliance theme SAVE (Stop America's Violence Everywhere), and with the encouragement of our medical society, our health promotion project, under the direction of Rita Talmonti and all of our county health promotions chairpersons, will be to publicize the 1-800-99-NO ABUSE number. At the preview session of our Alliance Annual Meeting on May 2, 1997, we announced this plan. We asked all advertising agencies in Michigan to submit a design for a poster to be used in an outdoor advertising campaign. Each county will then contact the outdoor advertising companies to donate available space as a public service to the citizens of Michigan, which will run in February of '98 to coincide with Valentine's Day. These posters also will be available for reprinting and distribution in the counties at local medical offices, hospitals, schools, houses of worship and businesses.

Legislative Goals

Our MSMS Alliance, under the leadership of Emily Strayhorn and Sharon VanderWall, will lobby our legislators to introduce and pass a bill calling for language on all marriage licenses to state: "This is a license to marry, not a license to abuse." Representative Patricia Godchaux

(R-Birmingham) of the 40th District has agreed to be the primary sponsor, and with a little luck this legislation will be introduced soon. On May 4, 1997, the MSMS House of Delegates passed a resolution to support our efforts in making this legislative initia-

tive a reality. This simple statement should give notice that violence does not solve problems for anyone.

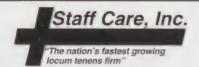
Supporting Education and Research

Our final lifeline is in the area of AMA-ERF. Your many fine efforts and innovative projects all go to help our medical students as they continue their educational opportunities to help insure that the fine medical education our physician spouses received will continue. Our support of research projects will continue to make new strides and to combat illnesses, and we will continue to have highly trained and skilled physicians to take care of the next generation, passing on a long and proud legacy of the best medical care available anywhere.

In order to get our message to the public, we are developing an "adopt a medical reporter" program. Each county may elect to order a subscription to *Alliance Today*, the AMAA publication and *Alliance in Action*, the MSMSA newsletter in the name of your favorite reporter. Valary Schroeder, our publications chair, has more information on this program.

I am now on the journey that will take me to many new places around the state. My hope is to get to know our membership better. The telephone is one of my best friends and I keep the U.S. Postal System awash with mail. Our Michigan State Medical Society Alliance will continue to strive to be innovative, cajoling and supportive.

The author is 1997-98 MSMS Alliance President.



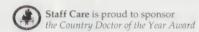
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Planning Keeps Us Moving on Right Track

By Peter A. Duhamel, MD

"Even if you're on the right track," Will Rogers said, "you'll get run over if you just sit there."

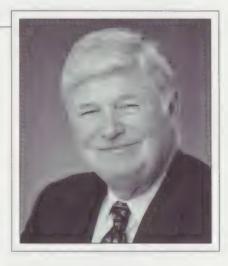
I agree. It's easy for an association to get complacent and stuck in the status quo. Fortunately, MSMS is not one of those associations. We have a history of not only being on the right track, but of building road beds, bridges and tunnels wherever necessary to get us to where we're

But getting somewhere obviously requires a plan. For many years, officers of the MSMS Board have developed a strategic plan to guide and prioritize MSMS activities. Last vear, however, the House of Delegates asked that we expand the planning group to include the widest possible perspectives.

So, on October 29, we are asking representatives of every county medical society, each specialty society, all MSMS sections, committee chairs, Alliance leaders and others to join the Board of Directors in developing an updated MSMS strategic plan.

Guiding our process that day will be Michael Skinner, PhD, a fiery consultant from Louisville and a fellow graduate of St. Louis University, who has worked with scores of associations and businesses across the United States.

Mike did some preliminary work with the Board in two intense sessions at the Midsummer Board Meeting in July. A quick review of the outcome of those sessions is included on pages 52-53 in this magazine. These ideas, among others, will become the basis of discussion and debate during the



October 29 meeting.

Mike is a former staff sergeant and medic in Vietnam and is a no-nonsense kind of guy. He broke us down into groups of six and then worked us into a friendly competitive frenzy to come up with our best ideas for the future of MSMS.

It's difficult to capture the excitement and enthusiasm generated during these planning sessions. Everyone got their say, no idea was a bad idea, but certain trends did start to emerge. Interestingly, they tended to mirror national trends in associations, Mike pointed out.

He said there are four areas where the best associations tend to focus. They are:

- · detailed and continuous plan-
- membership-driven activity;
- proactive rather than reactive thinking;
- effective two-way communication.

MSMS must and will continue to focus on these areas, among others,

to keep moving full speed ahead down the right track.

I urge you to participate in the MSMS planning process by completing the fax back survey on page 54. I will personally take your input to the October 26 Strategic Planning Meeting.

For information about that session contact Dave Fox at MSMS at (517) 336-5731 or dkfox@msms.org/ ■

Doctor Duhamel is MSMS President



"MMA provides an opportunity for we physicians to "buy-in' to an organization that will help us shape our practice environment into the future." Cathy O. Blight, MD, Flint



"MMA provides physicians in Michigan the ability to sculpt their practice environment for the future. It's a way for physicians to be proactive and to be able to evolve our marketplace." Robert J. Jackson, MD. Allen Park



"Physician empowerment and autonomy are vital to the survival and prosperity of the profession and to protecting patients' interests. MMA, in my view, is a critical factor in preserving that autonomy and creating that empowerment. A physician-owned and physician-minded organization like MMA provides me a level of trust I simply do not have with physician practice management companies and hospital systems.' Louis R. Zako, MD, Harbor Springs

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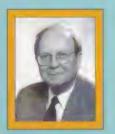
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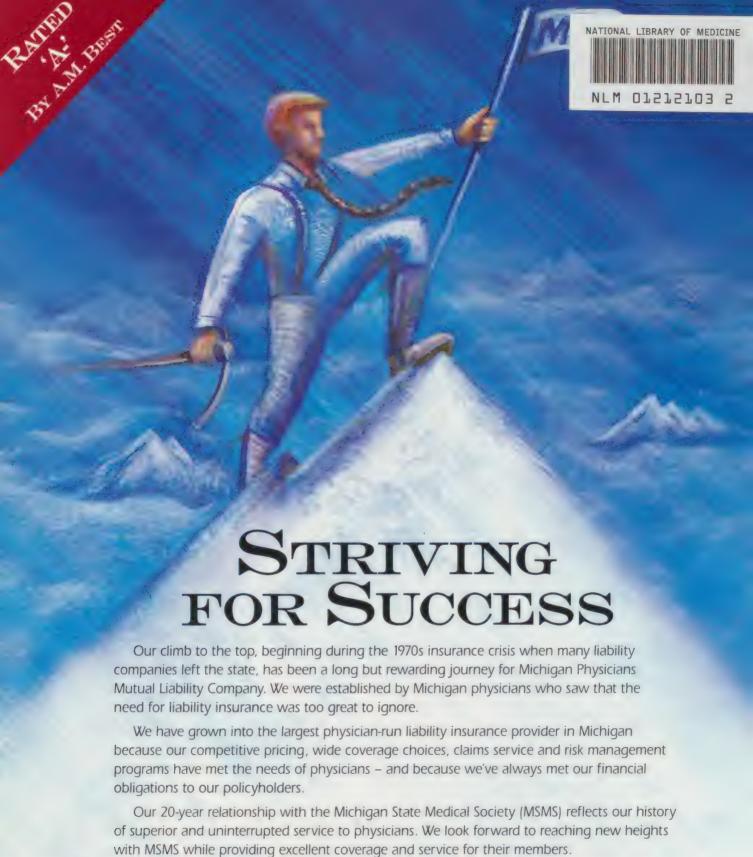
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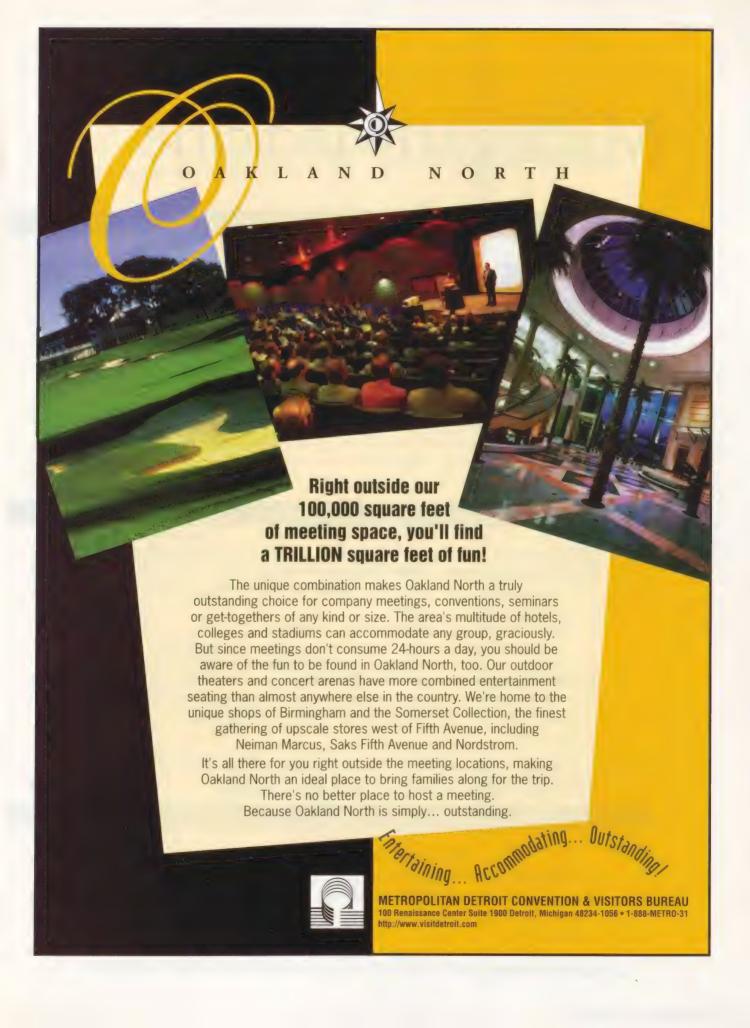
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COVER STORY



132nd Annual Scientific Meeting

10

The 132nd Annual Scientific Meeting sponsored by MSMS will be held at the Hyatt Regency Hotel in Dearborn on November 5-7, 1997. Thirty-one different CME programs and two plenary sessions will be presented throughout the three days for a maximum of 20 Category 1 credit hours. Also offered will be six courses for office managers, physicians and their staff members.

FEATURES

RISK MANAGEMENT

Risk Management Sites Debut on Internet

20

Have you had a nagging risk management question, but can't find the time to research the answer? We have some solutions.

By Frederick W. Minkow, MD, and Thomas C. Payne, MD

OFF DUTY

Local Physicians Run for Office

26

Williamston emergency room physician, Paul DeWeese, MD, prepares to run for state representative, and Bloomfield Township cardiologist, Gary Artinian, MD, is running for governor.

By Donna Kondek

VIEWPOINTS

Physician Responsibility and Accountability

30

Currently there are a number of medical issues before our state legislature, all with a common theme: public responsibility, accountability and the public good in a civil society.

By Roger Kahn, MD

PHYSICIAN PROFILES

Charles Zimont, MD & David R. Johnson, MD

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1997 winner of the MSMS Plessner Award for outstanding rural practice, offers a refreshing view of medicine.

Chief executive officer of the Michigan Department of Community Health discusses the demands and mission of his position.

October 1997 Volume 96, Number 10

MSMS Internet Website Address: http://www.msms.org/

MSMS E-mail Address: msms@msms.org



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Physician Accountability

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By Kathleen V. McKevitt

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A recent study of 2,000 association members nationwide asked current members why they do and do not participate in services, educational offerings, and activities. What do you think? By Michael G. Skinner, PhD

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MSMS, AMA and six national specialties release case study. By William Madigan and Tom Wolff

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Certified Medical Assistants

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Medical assistants are widely viewed by physicians as vital members of the health care delivery team. By Maxine R. Gordon, LPN, CMA

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Doctors and Their Families Make a Difference **Special Section**

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MSMS Board member praised by grateful patient

My name is Peggy Davis. I was recently an OB patient of Doctor Cecil R. Jonas. This letter represents a brief synopsis of Doctor Jonas' commitment to professionalism and his genuine concern for his patients. After I had had two miscarriages. and became pregnant for the third time, Doctor Jonas' comment to me was "we must get you a baby." His commitment to bringing this child to full term truly gave my husband and I the courage, stamina and perseverance we needed to go through yet another pregnancy.

Doctor Ionas placed me on complete bed rest at various times throughout my pregnancy, prescribed medication that would slow up my contractions, and monitored my pregnancy very closely until the baby was brought to full term. He was always there whenever I needed emergency care, and was never to busy to give good advice over the telephone. Because of his commitment to this pregnancy, on April 6, 1997, I gave birth to a healthy, fullterm 7 pound 6.4 ounce baby girl. My husband and I will always be grateful for the medical care we received at the hands of Doctor Cecil R. Ionas.

Lastly, I'd like to say that Doctor Ionas should be commended for his commitment to professionalism. I feel

that he is an asset to the medical profession, and more specifically to those women, such as myself, who are considered to be high-risk pregnancies. His peers and the medical community in general should feel proud to work alongside a doctor who has such high regard for professionalism. I am proud to have Doctor Ionas as my doctor and on behalf of my family. I extend to him a sincere heartfelt thanks. We applaud him for his dedication to his patients and his profession. As my daughter, Semaj' Elan Davis grows up, I will be sure to tell her about the wonderful doctor who took part in nurturing her. Again, we say thank you.

Mrs. Peggy Davis Detroit

CME required for retired physicians

Over time the Office of Health Services has noted that physicians who have retired from practice are, erroneously, assuming that they are no longer required to complete continuing education credits. This is not the case. If a person renews their license, he or she is responsible to have completed the continuing education credits. Physicians who are retired, or in the process of retiring, who want to keep their professional licenses, must complete continuing education hours. Allopathic physicians need to complete 150 hours of continuing education credits in order to legally renew their licenses. Failure to produce the documentation will result in a disciplinary sanction which may range from a reprimand and fine to a suspension of the individual's license.

There is no provision in the law for an individual to hold a "retired" license in an inactive status. A license is a license that authorizes an individual to practice. If you have any questions regarding these requirements, you may contact the continuing education program staff at (517) 335-0930.

Thomas C. Lindsay II Director, Michigan Office of Health Services

Internet training benefits member

Over the last few years, I have made efforts to decrease my computer illiteracy. The course given by William DeCourcy, chief, Internet Systems of MSMS was the best of the various courses I have attended. Mr. DeCourcy has encyclopedic knowledge of the subject and is a very good teacher. It is regrettable that the course at Walsh College was so poorly attended.

Emanuel Tanay, MD Grosse Pointe Park

Express your point of view in Michigan Medicine.

To submit a letter, mail, fax or e-mail it to Michigan Medicine, 120 W. Saginaw St., East Lansing, MI 48823; fax (517)337-2490; or e-mail jmarr@msms.org. Please type letters you submit for publication. Letters are published at the discretion of the editor and are subject to editing and abridament. Letters represent the opinions of the authors and do not necessarily reflect the policies of the Michigan State Medical Society.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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the Voice of 13,000 Michigan Physicians

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Video Conferencing

How to set up a low-cost 'net link in one hour

By William R. DeCourcy, Jr.

Many physicians are taking advantage of high-speed Internet links to conduct video conferences with their colleagues, friends and family. By following three steps, most Internet users will be able to set up a low-cost video communication link in less than one hour.

Obtaining the right hardware and software

In order to send video and sound over the Internet, your computer must be equipped with an audio-input and video-input device. Sound is processed within a computer via a device known as a "sound card." Most computers purchased within the last two years are equipped with sound cards, which receive audio input through a connected microphone. If your computer does not have a sound card, add-in devices—which allow audio input—can be purchased for less than \$100.

Most computers do not include a video-input device. These peripherals, which capture or process video images that your computer can send over the Internet, are available in two varieties. Computer video cameras include an integrated camera and input device that allows video to be streamed directly to the computer. The most popular of these units, the Connectix Color QuickCam, is available at most computer retailers for less than \$200.

This camera links to your computer via the printer and keyboard ports, which simplifies the installation process tremendously.

Video-input cards function by processing video signals from external devices, such as camcorders and VCRs. Because these cards typically use higher quality video devices for gathering the image, the picture generated will be of a higher quality than images created by most computer video cameras. Additionally, videoinput cards may be used for applications other than video conferencing. including video editing and digital photography. Video-input cards are available for less than \$300, and while most come with detailed instructions. they still require some level of computer expertise to install properly.

Once the video- and audio-input devices on your computer have been configured correctly, you need to obtain software that will allow you to communicate with other Internet users. There is currently no accepted standard for Internet video conferencing software, therefore, your computer and the computer of the Internet user you want to contact, need to be running the same program. The most functional and widely used Internet software for this type of connection is Microsoft NetMeeting 2.0. NetMeeting allows an unlimited number of Internet users to conduct a video and audio



conference, share files, type messages to one another, share applications like Word and Excel, and review documents in a collaborative environment. NetMeeting is available free of charge at http://www.microsoft.com/netmeeting.

Making the connection

In order to connect to another Internet user in a video conference, central computers are used to act as online meeting areas. These meeting areas, known as Internet Locating Server (ILS), allow Internet users who have video conferencing capabilities to select from a list of people with similar conferencing capabilities. Most online conferences are arranged in advance via e-mail, with the Internet address of an ILS and a predetermined time, which is the only information needed to schedule a meeting. By using the ILS system, you will be able to communicate with millions of Internet users from anywhere in the world, for the cost of a local phone call to your Internet service provider.

More information on Internet teleconferencing can be found at http://www.connectix.com, http://www.intel.com/imaging/isvr/index.htm and http://www.microsoft.com/netmeeting/features/

The author is Chief of Internet Systems for MSMS.

Surfing the Internet is a monthly feature of Michigan Medicine. If you have questions regarding MSMSNET content and/or links, contact Editor of Electronic Communications Claudia Skutar at cskutar@msms.org, or at (517) 336-5748. For technical questions about MSMSNET or Voyager Information Services, contact William R. DeCourcy, Jr. At MSMS at wdecourcy@msms.org or at (517) 336-7575.

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No liability for consultation with treating physician

By Richard D. Weber, JD MSMS Legal Counsel



Question: I often consult with treating physicians regarding their patients. I do not examine or treat the patients. In fact, I never even meet the patients. I do not bill for these consultation services. I simply make recommendations and sometimes give my opinion to the treating physician as a colleague. I am now rethinking whether I should continue to consult with my colleagues for the reason that I am told that I might have potential malpractice liability. Please comment.

Answer: In order for a malpractice claim to be viable, the physician must owe a legal duty to a patient. Such a duty arises from the physician-patient relationship. A physician-patient relationship is a legal prerequisite to a cause of action for medical malpractice against a physician. The question is, therefore, whether such consultation with a treating physician creates a physician-patient relationship.

In 1990, the Michigan Court of Appeals decided this issue for the first time in Michigan. The decision followed closely the arguments presented by MSMS in an amicus curiae brief filed on behalf of the defendant physician. In that case, the consulting physician gave his opinions about the case to the treating physician over the telephone. The consulting physician never had any contact with the patient or otherwise examined the patient. The patient gave birth to a mentally handicapped child and filed suit against the consulting physician, arguing that substandard advice was given during the telephone conversations and that the consulting physician was therefore liable for medical malpractice.

The consulting physician never examined or spoke with the plaintiff patient. The consulting physician's opinions were addressed solely to the treating physician. The court held that these consultations between the consulting physician and treating physician did not rise to a physicianpatient relationship and, therefore, there was no legal cause of action for medical malpractice. The Michigan appellate court opined that the extension of malpractice liability to physicians who merely confer with the treating physician, without more, "would unacceptably inhibit the exchange of information and expertise among physician. This benefits neither those seeking medical attention nor the medical profession."

The rule of law that consultation with the treating physician does not in and of itself create a physicianpatient relationship was reaffirmed by the Michigan Court of Appeals earlier this year. Based upon the 1990 decision, the court held that a physician consulting with a treating physician, even on multiple occasions, could not be sued for medical malpractice when the consulting physician never had any contact with the patient. In the 1997 case,

there were numerous consultations and the consultant physician even examined the patient's chart on one occasion. Nevertheless, the Court of Appeals followed precedent and held that such facts do not create a physician-patient relationship and, therefore, a medical malpractice lawsuit could not proceed.

Based upon these Michigan appellate court decisions, it does not appear that you, as a consultant to the treating physician, would create any physician-patient relationship that could form the basis of medical malpractice liability. If a consulting physician had any contact with the patient, however, either in person or by telephone or other electronic means, the answer would probably be different. In addition, if the consulting physician submitted a bill for the consultation, the answer would probably be different. Mere consultation with a colleague without more should not form the basis of a physician-patient relationship that is an essential prerequisite to a malpractice lawsuit. To do otherwise would inhibit the exchange of information and expertise among physicians and benefit neither patients, the medical profession or the public in general. This argument, which was asserted by MSMS in its amicus curiae brief and accepted by the court, represents sound reasoning.

Mr. Weber is MSMS legal counsel and senior partner in the Detroit firm of Kerr, Russell and Weber.

Editor's Note: If you have legal questions you would like answered by MSMS legal counsel in this column, jot them down and send them to Judith Marr, Editor, P.O. Box 950, East Lansing, MI 48826-0950, or e-mail her at jmarr@msms.org.

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NOVEMBER 5, 6 & 7, 1997



THE HYATT REGENCY, DEARBORN

'97 MSMS Scientific Meeting

Up to 20 CME credits awarded;

new track for physicians' staff members

By Colleen M. Horton

The 132nd Annual Scientific Meeting sponsored by MSMS will be held at the Hyatt Regency Hotel in Dearborn on November 5-7, 1997. The meeting will return to the Hyatt after being held in Lansing for the previous two years and at the Dearborn Inn a year before that.

Registration opens at 6:30 a.m. on Wednesday, November 5 with the first courses beginning at 8:30 a.m. All educational courses and special functions will be held at the hotel unless otherwise noted. Thirty-one different CME programs and two plenary sessions will be presented throughout the three days for a maximum of 20 Category 1 credit hours. Also offered will be six non-CME courses for office managers, physicians and their staff members. Each half-day course awards three credit hours unless otherwise indicated, and the plenary sessions on Thursday and Friday morning are each worth an additional 1 hour of Category 1 CME credit.

A new feature of this year's ASM will be courses offered in computer technology. On Friday, November 7, Technology Symposium-Part I will be an educational forum for physicians who are interested in learning about the clinical applications of new medical technologies. This course will feature a hands-on medical exhibit area where many of the technologies featured in the symposium will be available for demonstration. Topics to be discussed at these technology sessions will include "Telemedicine," "Computer Medical Decision Aids," "Medical Search Engines," "Electronic Medical Records," and "Universal Service Funds."

Another addition to this year's ASM will be a segment of courses relating to the business aspect of running the physician's practice. "Designing Business Strategies" will be presented on Wednesday morning by course directors Kenneth M. Hekman, FACPME, President, Hekman & Associates Inc., Holland and David

Kepley, Consultant, Michigan Medical Advantage, East Lansing. The purpose of this course is to demonstrate how strategic business planning can serve to extend and protect the viability of physician practices. "Mergers, Consolidations and Fair Market Value," is designed to help physicians know how to position their practices for a beneficial sale or merger, how to use an appraisal as a vital negotiating tool, and how to gauge the compatibility of potential allies.

Many courses being offered this year are designed to educate the physician's office manager and staff about the importance of customer service. "Customer-Oriented Medical Practice Part I and Part II" will stress the importance of customer service in the medical practice and the roll of the office staff member in promoting a customer oriented atmosphere. Through group discussion, creative ideas for enhancing the patient's satisfaction with care will be explored with emphasis placed on solving common patient complaints - the telephone, the reception/waiting area and the collection process. Another important course designed for physician and staff is "E-M Coding & Documentation." This course will discuss in detail the decision process, definitions and the documentation guidelines that HCFA and other payers will use to determine whether the proper code(s) were submitted. Tips on documentation, key diagnosis coding guidelines including 1998 changes will be discussed.

Plenary sessions on Thursday and Friday begin at 7 a.m. and are free. Morning courses are from 8:30 a.m. until 12:00 p.m. with lunch from 12:00 p.m. to 1:30 p.m. Afternoon courses begin at 1:30 p.m. until 5 p.m. A buffet-style lunch included in your registration fee will be located in the MSMS Patrons Forum with registration, coat check and refreshments.

The author is MSMS communications assistant.

WEDNESDAY MORNING. **NOVEMBER 5. 1997**

All morning courses run from 8:30 a.m. to 12:00 p.m. with a half-hour break

Lunch provided in sponsor forum from 12:00 p.m. to 1:30 p.m.

BASIC CARDIAC LIFE SUPPORT

PRESENTED BY: American College of Emergency Physicians, Michigan Chapter. This course will teach and review Basic Cardiac Life Support, the role of the health care professional and the community in the emergency cardiac care system, information and techniques needed for adult and pediatric cardiopulmonary resuscitation, special rescue situations and ethical and legal considerations in CPR. This course is limited to 30 participants.

COURSE DIRECTOR: Kathleen Fenske, MD, Emergency Medicine, Sparrow Health System, Lansing.

DERMATOLOGICAL USE OF LASERS

PRESENTED BY: Michigan Dermatological Society. This course will focus on the treatment of skin diseases by laser techniques; hemangiomas, tattoos, wrinkles, and birthmarks.

COURSE DIRECTOR: Ali Moiin, MD, CME Chair, Michigan Dermatological Society.

BRAIN ATTACK

PRESENTED BY: Michigan Association of Neurological Surgeons. Stroke is the second leading cause of death and should be treated as an emergency like a heart attack. The Brain Attack gives an update on current management and diagnosis to decrease mortality/morbidity of stroke.

COURSE DIRECTOR: Reynaldo G. Castillo, MD, President, Michigan Association of Neurological Surgeons.

PEDIATRICS: PEARLS AND PITFALLS

PRESENTED BY: DeVos Children's Hospital, Grand Rapids. This course will discuss shaken baby syndrome, apparent life-threatening events, advances in the treatment of childhood cancer, and childhood bleeding disorders.

COURSE DIRECTOR: Nabil E. Hassan, MD, Pediatric Intensivist, DeVos Children's Hospital, Grand Rapids; Assistant Professor, Department of Pediatrics, Michigan State University College of Human Medicine.

RADIOLOGY FOR CLINICIANS

PRESENTED BY: Michigan Radiological Society. This course is designed to provide insight and current views in various aspects of radiology: radiological evaluation for dyspepsia and epigastric pain; the role of MRI in evaluation of the breast; review of diagnostic and therapeutic interventional radiological procedures; and the utility of MRI in visceral and peripheral angiography.

COURSE DIRECTOR: A.P. Zingas, MD, FACR, Department of Radiology, Harper Hospital, Detroit.

*DESIGNING BUSINESS STRATEGIES THAT WORK FOR YOU

(*This course will be conducted for physicians, office managers and staff members. It will not receive CME credit.)

PRESENTED BY: Michigan Medical Advantage, East Lansing. Seasoned consultants will show you how to pinpoint the changes that can benefit you most, demonstrate how a unique planning model has worked for other practices, and offer a statistical overview of trends in the medical marketplace to jumpstart your planning efforts.

CO-DIRECTORS: Kenneth M. Hekman, FACMPE, President, Hekman & Associates Inc., Holland and David Kepley, Consultant, Michigan Medical Advantage, East Lansing.

*THE CUSTOMER-ORIENTED MEDICAL PRACTICE - Part I

(*This course will be conducted for physicians, office managers and staff members. It will not receive CME credit.)

PRESENTED BY: Pollex Consulting, PC, Southfield. Through group discussion, creative ideas for enhancing the patient's satisfaction with care will be explored and strategies for improving time management and office efficiency will be included.

COURSE DIRECTOR: Julia A. Pollex. President, Pollex Consulting, PC.

WEDNESDAY AFTERNOON. NOVEMBER 5, 1997

All afternoon courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break.

BASIC CARDIAC LIFE SUPPORT

PRESENTED BY: American College of Emergency Physicians, Michigan Chapter. This course will teach and review Basic Cardiac Life Support, the role of the health care professional and the community in the emergency cardiac care system, information and techniques needed for adult and pediatric cardiopulmonary resuscitation, special rescue situations and ethical and legal considerations in CPR.

COURSE DIRECTOR: Kathleen Fenske, MD, Emergency Medicine, Sparrow Health System, Lansing.

PAIN MANAGEMENT AND END-OF-LIFE CARE

PRESENTED BY: MSMS Committee of Hospice Medical Directors. This course will provide practical information about palliative medicine. Through half hour presentations, the course material will include an introduction to hospice care, the benefits of early referrals, hospice utilization, treatment of dyspnea, role of supplemental nutrition, and use of oral morphine for pain control.

COURSE DIRECTOR: Thomas M. George, MD, Medical Director, Hospice of Greater Kalamazoo.

FREQUENTLY ENCOUNTERED **NEUROLOGICAL PROBLEMS**

PRESENTED BY: Department of Neurology, Wayne State University School of Medicine. This course will provide practical information about frequently encountered neurological problems for primary doctors and nonneurologists including epilepsy, multiple sclerosis, Parkinson's disease and stroke.

COURSE DIRECTOR: Paul A. Cullis, MD, Department of Neurology, Wayne State University School of Medicine.

QUALITY IMPROVEMENT IN CARDIOVASCULAR CARE

PRESENTED BY: Center for Health Outcomes and Evaluations. Can quality improvement projects improve the quality of medical care? Through presentation and discussion of the Center's successful statewide quality improvement projects in Acute Myocardial Infarction and Congestive Heart Failure, course participants will become informed consumers of and participants in state-of-the-art clinical quality improvement activities.

COURSE DIRECTOR: Thomas J. Ruane, MD, Principal Clinical Coordinator, Center for Health Outcomes and Evaluation, Plymouth.

OBESITY MANAGEMENT

PRESENTED BY: Preventive and Nutritional Medicine, William Beaumont Hospital, Birmingham. This course will provide primary care physicians, internists and other specialists a set of guidelines for treating obesity.

COURSE DIRECTOR: Charles Lucas, MD, Chief, Preventive and Nutritional Medicine, William Beaumont Hospital, Birmingham.

PEER REVIEW - NEW DIMENSIONS AND NEW IMPORTANCE

PRESENTED BY: Physician's Review Organization of Michigan (PROM). This course is to examine the changing dynamics and importance of the peer review process and its implication for clinical practice in the age of managed care. Faculty will analyze case studies to assess and monitor the impact of "managed care."

COURSE DIRECTOR: Donald C. Smith, MD, Medical Director, PROM.

*THE CUSTOMER-ORIENTED MEDICAL PRACTICE - Part 2

(*This course will be conducted for physicians, office managers and staff members. It will not receive CME credit.)

PRESENTED BY: Pollex Consulting, P.C., Southfield. Emphasis will be placed on the "business" areas of a medical office which commonly contribute to patient complaints - the telephone, the reception/waiting area and the collection process. It will examine how the actions of staff can hinder or promote patient satisfaction.

COURSE DIRECTOR: Julia A. Pollex, President, Pollex Consulting, PC, Southfield

THURSDAY MORNING. **NOVEMBER 6. 1997**

All morning courses run from 8:30 a.m. to 12:00 noon with a half-hour break

Complimentary coffee available at 7:00 a.m. Lunch provided in Sponsor Forum from 12 Noon - 1:30 p.m.

BASIC CARDIAC LIFE SUPPORT

PRESENTED BY: American College of Emergency Physicians, Michigan Chapter. This course will provide certification in Basic Cardiac Life Support, the role of the health care professional and the community in the emergency cardiac care system, information and techniques needed for adult and pediatric cardiopulmonary resuscitation, special rescue situations, and ethical and legal considerations in CPR.

COURSE DIRECTOR: Kathleen Fenske, MD, Emergency Medicine, Sparrow Health System, Lansing.

ALLERGIC RHINITIS AND LATEX **ALLERGY**

PRESENTED BY: Michigan Allergy and Asthma Society. This course, designed for both primary care physicians and specialists, will provide information on diagnosis, management and treatment of allergic rhinitis and other allergic conditions, including latex allergy.

COURSE DIRECTOR: Wayne Pierantoni, MD, Private Practice, Grosse Pointe Allergy and Immunology, Eastpointe.

BREAST CANCER THERAPY: A MULTI-SPECIALTY APPROACH

PRESENTED BY: Michigan Academy of Plastic Surgeons

This course will describe to the general practitioner the multi-specialty team approach to the care of breast cancer patients and how they function as a cohesive group to devise the best treatment options available for patients diagnosed with breast cancer. A multidisciplinary team includes: a general surgeon, a radiation oncologist, a medical oncologist, a nurse oncologist, a pathologist, a plastic surgeon, a radiologist, a geneticist, a research nurse, and a social worker.

COURSE DIRECTOR: Vigen B. Darian, MD, FACS, Department of Plastic Surgery, Henry Ford Hospital, Detroit.

RECOGNITION AND TREATMENT OF COMMON TRAUMATIC AND ATHLETIC ORTHOPAEDIC INJURIES IN CHILDREN

PRESENTED BY: Michigan Orthopaedic Society. This course is designed for pediatricians and primary care physicians and will discuss how to prevent and recognize traumatic and athletic orthopaedic injuries in children.

COURSE DIRECTOR: James A. Goulet, MD, Associate Professor of Orthopaedic Surgery, Director of Orthopaedic Trauma Service; University of Michigan Medical Center. President of Michigan Orthopaedic Society.

GUIDELINES IN THE MULTIDISCIPLINARY MANAGEMENT OF PROSTATE CANCER

PRESENTED BY: Karmanos Cancer Institute, Wayne State University School of Medicine. This course will discuss controversies of local, advanced and metastatic prostate cancer and will identify treatment options.

COURSE DIRECTOR: Arthur T. Porter, MA, MD, FRCPC, FACRO, Professor and Chair, Department of Radiation Oncology, Wayne State University School of Medicine, and Director of Clinical Care, Karmanos Cancer Institute.

*MERGERS, CONSOLIDATIONS AND FAIR MARKET VALUE

(*This course will be conducted for physicians, office managers and staff members. It will not receive CME credit.)

PRESENTED BY: Michigan Medical Advantage, East Lansing. Medical integration is becoming one of the strongest themes for physicians in this decade. This session will give physicians information concerning the merger and consolidation of their practices, including review of legal, financial, and operational decisions that should be discussed when consolidating medical practices. This session will describe how to position your practice for a beneficial sale or merger, how to use an appraisal as a vital negotiating tool, and how to gauge the compatibility of potential allies.

COURSE DIRECTOR: James Aluia, Manager, Physician Networks & Practice Management, Michigan Medical Advantage, East Lansing.

*A PHYSICIAN'S GUIDE TO **EVALUATION AND** MANAGEMENT CODING AND **DOCUMENTATION**

(*This course will be conducted for physicians, office managers and staff members. It will not receive CME credit.)

PRESENTED BY: Department of Medical Economics and Health Care Delivery, Michigan State Medical Society. A team approach to documentation for coding evaluation and management services, including definition and guidelines from HCFA and other payers will be discussed. Managers are encouraged to attend with physician or clinical staff. This course is limited to 50 participants.

COURSE DIRECTOR: Joyce Nurenberg, Reimbursement Ombudsman, Department of Medical Economics and Health Care Delivery, Michigan State Medical Society

THURSDAY AFTERNOON. NOVEMBER 6, 1997

All afternoon courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break.

MANAGEMENT OF CHRONIC PAIN IN THEORY AND IN PRACTICE

PRESENTED BY: University of Michigan Neuromodulation Program. This course will provide a rational approach to the evaluation, diagnosis and treatment of patients with chronic pain through a series of presentations. Indications for consultation and invasive procedures will be discussed. The use of intrathecal narcotics and neurostimulation in the treatment of chronic pain will be reviewed, and participants will have the opportunity to examine the implants typically used.

COURSE DIRECTOR: Oren Sagher, MD, Director of Neuromodulation Program and Assistant Professor, University of Michigan Medical School.

THE SPECTRUM OF ANAPHYLAXIS

PRESENTED BY: Departments of Internal Medicine and Pediatrics, Wayne State University School of Medicine and VA Medical Center, Detroit. This course will be of interest to all physicians and will review basic diagnosis and treatment of anaphylaxis.

COURSE DIRECTOR: Michael R. Simon, MD, Training Program Director, Allergy

and Immunology, Detroit Medical Center and VA Medical Center; Associate Professor, Pediatrics and Internal Medicine, Wayne State University School of Medicine.

NUANCES OF BREAST RECONSTRUCTION

PRESENTED BY: Michigan Academy of Plastic Surgeons . The focus of this three-hour discussion will be to describe to the general plastic surgeon the refinements involved with breast reconstruction in the 1990s. Time will be reserved for questions and discussion of participants' own cases.

COURSE DIRECTOR: Vigen B. Darian, MD, FACS, Senior Staff Surgeon, Department of Plastic Surgery, Henry Ford Hospital, Detroit.

ORTHOPAEDIC SPORTS MEDICINE APPROACH TO OCCUPATIONAL **INJURIES**

PRESENTED BY: Michigan Occupational and Environmental Medical Association. This course will discuss sports medicine management of occupational musculoskeletal injuries, including shoulder, arm, hand, spine, and knee disorders.

COURSE DIRECTOR: Shlomo S. Mandel, MD, Staff Physician, Henry Ford Hospital Center for Athletic Medicine, Detroit.

SAVING THE DIABETIC FOOT

PRESENTED BY: Michigan Infectious Diseases Society. Upon completion of this course the participants should be able to describe the epidemiology and pathogenesis of the diabetic foot, assess the diabetic foot for complication, determine the latest treatment methods, and determine the latest strategies to prevent the diabetic foot ulcer.

COURSE DIRECTOR: H. Gunner Deery II, MD, FACP, FIDSA, Department of Infectious Diseases, Burns Clinic, Petoskey.

BREAST CANCER DIAGNOSIS: MEDICAL AND LEGAL RISK MANAGEMENT PRINCIPLES

PRESENTED BY: Michigan State Medical Society/Michigan Physicians Mutual Liability Company Risk Management Committee. This course, intended for primary care physicians and specialists, will focus on early detection, followup and referral, including communication with patients from culturally diverse backgrounds, in the diagnosis of breast cancer.

COURSE DIRECTOR: Thomas Payne, MD, Past-president of Michigan State Medical Society; Chair, MSMS Risk Mangement Committee, East Lansing

*REGULATIONS IN THE PHYSICIAN'S OFFICE: WHO'S LOOKING OVER YOUR SHOULDER?

(*This course will be conducted for physicians, office managers and staff members. It will not receive CME credit.)

PRESENTED BY: Michigan Department of Community Health. This course will address visits to physician offices, including HMO site reviews, bloodborne pathogens, medical waste handling, CLIA and pharmacy review.

COURSE DIRECTOR: John D. Gardner. Chief, Delivery System Section, Managed Care Quality Assessment and Improvement Division, Michigan Department of Community Health

FRIDAY MORNING. NOVEMBER 7, 1997

All morning courses run from 8:30 a.m. to 12:00 noon with a half-hour break.

Complimentary coffee is available at 7:00

Lunch provided in Sponsor Forum from 12 Noon to 1:30 p.m.

SPECIAL HYPERTENSION **POPULATION**

PRESENTED BY: Wayne State University School of Medicine. This course addresses the issues of hypertension associated with special populations including African Americans, the elderly, diabetics and those with secondary causes of hypertension.

COURSE DIRECTOR: James R. Sowers, MD, Director, Division of Endocrinology, Wayne State University School of Medicine

WHAT'S NEW WITH THE NOSE?

PRESENTED BY: Michigan Otolaryngological Society. This course will provide primary physicians with the latest information regarding the pathogenesis and treatment of rhinosinusitis and allergic rhinitis.

COURSE DIRECTOR: Brent A. Senior, MD, Senior Staff, Henry Ford Health System, Detroit.

RISKS AND BENEFITS OF MENOPAUSAL HORMONE REPLACEMENT THERAPY

PRESENTED BY: Wayne State University School of Medicine and Hutzel Hospital, Detroit. This course will review the major benefits. risks, and complications of HRT, and their management. The course is suitable for all physicians interested in women's health.

COURSE DIRECTOR: Kamran S. Moghissi, MD, Professor, Reproductive Endocrinology, Hutzel Hospital, Detroit.

SAVE 100: INTRO TO QUALITY, COST-**EFFECTIVE PRESCRIBING**

PRESENTED BY: WSU-OHEP Medical Education Consortium

This course will discuss the innovative WSU-OHEP program to educate physicians how to factor costs into treatment decisions. The program plans to give information to 10,000 doctors about the relative costs of prescription drugs in the five areas that make up about 60 percent of prescribing costs. Doctors will be given a "prescription-database best-buy card" that lists drug names and prices.

CO-COURSE DIRECTORS: Willis H. Stephens, MD, Past President, Planning Chairman WSU-OHEP Medical Education Consortium and Ernest M. Hammel, PhD, Executive Director, OHEP Center for Medical Education, Southfield

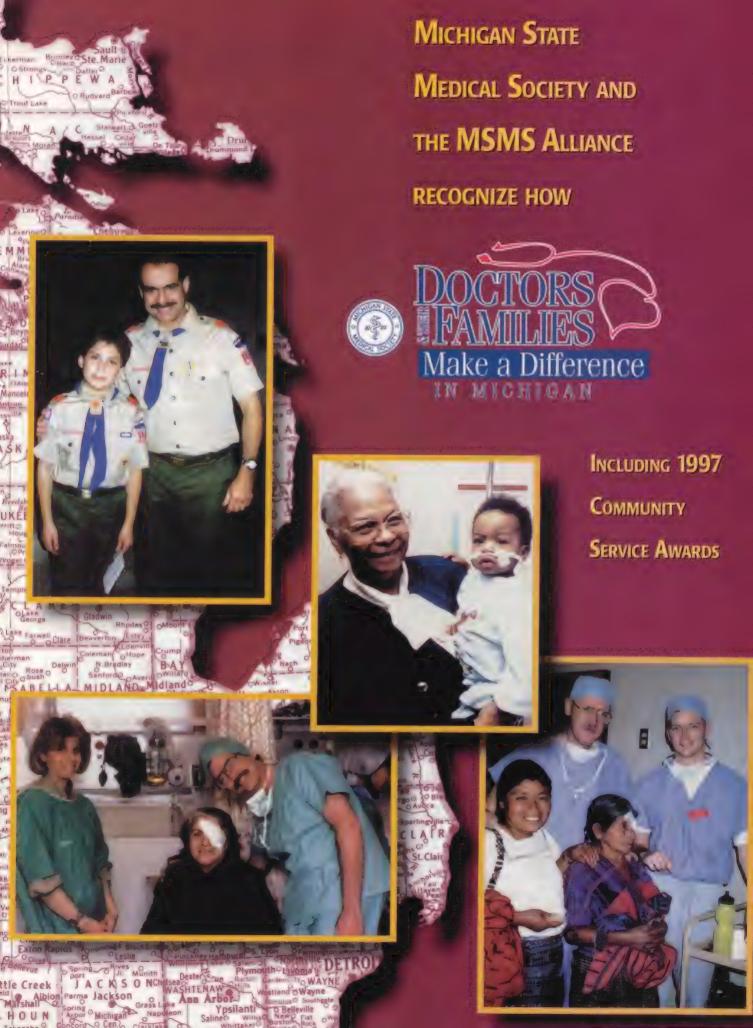
TECHNOLOGY SYMPOSIUM-Part 1

PRESENTED BY: Michigan State Medical Society Committee on Technology in Medicine. The MSMS Technology in Medicine Symposium is an educational forum for physicians who are interested in learning about the clinical applications of new medical technologies. In addition to educational sessions, the Technology in Medicine Symposium will feature a handson medical exhibit area where many of the technologies featured in the symposium will be demonstrated.

COURSE DIRECTOR: David R. Rovner, MD, Assistant Dean of Technology, Michigan State University College of Human Medicine, East Lansing.

HANDS-ON INTRODUCTION TO COMPUTERS AND THE INTERNET

PRESENTED BY: Michigan State Medical Society Committee on Technology in Medicine. This course will be conducted off-site. Please







Like so many others from every walk of life, Michigan physicians and their families contribute in a variety of ways to the well-being of their communities. As volunteers, they work quietly and without formal recognition, and they are happy to do so.

We are pleased to have learned about some of their activities, and share them with you here. These stories represent just a fraction of the volunteer activity taking place, but they illustrate the variety of the work being done, and the depth of commitment among doctors and their families to worthy causes.

As national Make a Difference Day is recognized, we are proud to recognize the efforts of Michigan doctors and their families to improve their communities, their schools and churches and the lives of those in need. We are especially proud to present to you the recipients of the 1997 Michigan State Medical Society Community Service Award, sixteen outstanding individuals nominated by their county medical societies for exemplary volunteer work.

This document is a tribute to them, and to all Michigan physicians and their families who make a difference. We thank them and encourage others to follow their example.

Peter A. Duhamel, MD MSMS President

Blanche L. Mindlin
MSMS Alliance President

Tissy Ansbacher of Ann Arbor is "a most valued and valuable volunteer" according to Arbor Hospice. Five years ago, Tissy began what is lovingly known as the "Tree of Remembrance." Every year she and her corps of volunteers produce 3,500 handmade ornaments that are sold in memory of someone deceased. The ornaments are then hung on the "Tree" that is displayed at a mall in Ann Arbor. Once the tree comes down, the ornaments are forwarded to the family that purchased them.

Paul Karr, MD of Burton, is the medical director of the Genesee County Free Clinic. His wife, **Joey**, heads up the St. Joseph Guild of the Holy Redeemer Church where she puts in many hours each week maintaining the gardens and landscaping.

Michigan State Medical Society Alliance members have brought canned goods to each Alliance meeting, benefiting food banks in Genesee, Kent, Midland and Oakland counties.

Cary M. Bjork, MD, of Marquette, his wife, Sharon and their three sons, Bryan, Adam and Jonathan, spent July in Kampola, Uganda working for Health Volunteers Overseas. Cary taught at Mulago Hospital of the Makerere University Medical School while Sharon helped teach a class of 116 first graders at Kitente Primary School. Adam and Jonathan studied the behavior of DeBrazza's monkeys and prepared a report for the Uganda Wildlife Education Centre in Entebbe, Uganda.



Cary Bjork, MD, and his entire family have done extensive volunteer work in Uganda and Ecuador, as well as in their hometown of Marquette.





- Mark Sheldon, MD, and Scott Weber, MD, of Grand Rapids have established an eye care clinic for low income patients. When it was determined that "service" was not enough, they established a nonprofit organization, *Vision Care West Michigan*, to provide help with spectacles.
- **Mjr. Richard Stone, MD,** and his wife, **Capt. Jenny Stone** of Clinton Township are members of the United States Army Reserve. One weekend a month they train army medics to provide hospitalization and surgical care on the battlefield.
- James J. Maurer, MD, of Battle Creek is an involved chairman of the Marian E. Burch Adult Day Care Center Advisory Board. He has given over 10,000 hours of dedicated volunteer service since 1989 which ranged from supervising construction of the 16,250 sq. foot center to building linkages with other health care service providers.

The Kalamazoo Academy of Medicine Alliance will collect personal items like shampoo and deliver them to the local women's shelter. They are also sponsoring an informational "Day at the Doctor" booth at the Bronson Family Health Fair.

- Peter F. Gordon, MD, a family practice physician in Sterling Heights fights to prevent drug, alcohol and tobacco use. A founding member of the Troy Coalition for Substance Abuse Prevention and several similar groups throughout southeastern Michigan, Doctor Gordon was named "Citizen of the Week" by WWJ Radio in Detroit.
- **Stewart Hamilton, MD,** of Flint, is a volunteer member of the Michigan Diabetes Coalition, chair of the Diabetes Task Force, Greater Flint Health Coalition, chairman of the Diabetes Policy Advisory council to the Michigan Department of Community Health as well as a volunteer for the Genesee County Free Medical Clinic.
- Virgillo Villarreal, MD, of Burton is a volunteer for the Spanish Speaking Information Center and a volunteer physician to Vietnam. His wife, **Ana Maria** Villarreal, is an auxiliary volunteer at McLaren Hospital.

Robert Pool, MD, of Bloomfield Hills has undertaken many medical missions to South America and Africa to provide corrective plastic surgery for those in need. His area of interest has been the surgical repair and treatment of cleft palates.

Ingham County Medical Society Alliance members are busy raising money for a scholarship fund. They also are involved in "Operation Spirit Lift" to collect gifts to be distributed to recipients of Lansing's Refuge Services.

- **Susan S. Thoms, MD,** of Livonia, teaches classes to visually impaired youth at the Salvation Army's summer camp at Echo Grove. She also donates time on Saturdays to provide glaucoma screening to the public at southeastern Michigan's "Project Health-O-Rama."
- Martin L. Weissman, MD, of West Bloomfield, has traveled on many medical missions to provide orthopedic care through Project Hope. Doctor Weissman was sent to Grenada to assess the need for an orthopedist and returned eight months later with supplies and equipment to open and operate an orthopedic surgery center where over 100 surgeries were performed in a two-month period. He also trained indigenous medical personnel while there.
- **Scott Wilkinson, MD,** and his wife, **Jill,** of Pontiac traveled to Beleze, Central America with Benevolent Missions International to perform surgery on patients with ophthalmological problems. Doctor Wilkinson and another ophthalmologist performed over 60 operations in four days. While Doctor Wilkinson performed surgery, Jill assisted in running the clinic.
- **Suzie MacKeigan**, wife of **John M. MacKeigan**, **MD**, of Grand Rapids, has served as a mentor to several inner city Hispanic children every week for the past several years.

Muskegon County Medical Society Alliance will be donating the proceeds from the sale of "People Pins" to the local domestic violence center.



Steven Bolton, MD, founded "Mercy Place," a clinic providing medical care to the underserved population in the Pontiac area. He also provides care there on a regular basis.

Michelle M. Condon, MD, of Grand Rapids and her daughter **Kelsey** are both dedicated volunteers. "Doctor Mom" has coached Kelsey's girls soccer in



East Grand Rapids, assisted with local Brownie Girl Scout meetings and shuttled local needy persons to church-sponsored community dinners. Together they deliver Christmas and Easter plants to the elderly and disabled and they make cotton candy at Kelsey's school fund raisers. Kelsey enjoys playing the

piano at Hospice Home of Hope while Doctor Condon sees patients.

Julie Maier, RN, wife of Thomas J. Maier, MD, of Battle Creek provides TB tests to each individual who resides at the local homeless shelter. Every Friday at 6:30 a.m. she organizes a list of those living at the shelter who have not been tested and provides them with free tests. She also is involved in raising money for a renovation project which will provide more beds for homeless men, women and children in the community.

Thomas M. George, MD, of Kalamazoo, and his family were a host family for visiting players in the Little League Softball World Series. **Sandy George** is an assistant Girl Scout Leader.

John Collins, MD, and **Philip Ptacin, MD,** of Battle Creek, helped to establish a medical clinic to serve the indigent population of Battle Creek and spend countless hours volunteering their time and medical services.

Christine D. Pareigis, MD, of St. Joseph, provides her services free of charge to the Pediatric Rehabilitation Clinic. At least once a month she provides services to the tri-county area of Berrien, Van Buren and Cass counties with a caseload of close to 200 children with varying degrees of disabilities.



Juan L. Rodriguez, MD, of Beverly Hills, has been a Boy Scout Webelos Den Leader, Cub Master, Assistant Scout Master, Merit Badge Counselor and Coordinator for Eagle Courts of Honor. He also holds weekly meetings with scouts and bi-weekly meetings for Cub Scouts and Webelos.

Adrian J. Christie, MD, is the past Vice President of the Board of Don Bosco Hall, a boys' foster home in Detroit. He is also a board member of the Community Treatment Center, an alternative sentencing program and drug rehabilitation center.

Karl J. Edelmann, **MD**, of Ann Arbor, and his wife, **Jackie**, helped establish Pack 1 of the Cub Scouts at Spiritus Sanctus Academy. Jackie is a den mother and Doctor Edelmann is a committee chair. In the two years since it began the pack has doubled in size.

Carol A. Krieg, MD, of Escanaba, went to Kazakstan for 16 days on a medical mission with Operation Blessing Flying Hospital. Doctor Krieg performed 70 eye surgeries on patients ranging from infants to the elderly.



Ophthalmologist Carol Krieg, MD, performed eye surgeries for many needy patients in Kazakstan.



The Nursing Clinic of Battle Creek is staffed by thirteen physician volunteers: Maddur Badarinath, MD; KaaKish Bhan, MD; Atmaram Bhansal, MD; John Collins, DO; Sudhir Desai, MD; Stephen Fedele, DO; Montie Gould, MD; Richard Cranz, MD; William Mayer, MD; Phillip Ptacin, MD; Donald J. Stianar, MD; Jose Valle, MD; and John Young, MD.

The Kent County Alliance Foundation will receive and administer funds to operate charitable scientific and educational programs.

Alan M. Mindlin, MD, of Bloomfield Hills, has a long history of volunteerism. He still makes house calls and is willing to see patients in emergency situations regardless of their ability to pay. Doctor Mindlin and his family helped start Temple Shir Shalom in West Bloomfield, which grew from 30 families to a congregation of over 750. He and his wife, Blanche, have become Rabbinical Aides and the Mindlin daughters, Alicia and Bethany, asked everyone attending their Bat Mitzvahs to bring mittens and hats to the services to be distributed to those less fortunate. They have also participated in Habitat for Humanity and Days of Caring in their schools.

M. Gary Robertson, MD, of Grand Haven is the chairman of the board for the Tri-cities Family YMCA, an Elder in the First Presbyterian Church of Grand Haven, and a past board member of the American Cancer Society and North Ottawa Chamber of Commerce. Penny Robertson, his wife, volunteers in a reading program at Central Elementary school, and has been a board member and volunteer nurse for the Red Cross. She is also a past volunteer nurse for Hospice and a past board member of the YMCA.

Ian T. Jackson, MD, of Southfield is a plastic surgeon who, once a month, operates on someone who is unable to get funding for surgery, often coming from outside the United States.

Wayne County Medical Society Alliance will host a major fund raising effort to coincide with both United Nations Day and Make a Difference Day. Proceeds will be divided between a shelter and Red Cross Disaster Relief.

Joseph W. Hosner, MD, an ophthalmologist in Kalamazoo traveled to Santarem, Brazil to perform cataract surgeries on indigent people living in the rain forest. While there he produced a teaching video on how to organize a mission and how to remove cataracts during missions without modern equipment.



Joseph Hosner, MD, has performed cataract surgeries on indigent people in Brazil's rain forest.

Dree Lo, wife of **Gus Lo, MD,** of Petoskey, designed and wrote the script for a community resource brochure titled "Should I send my child to school today?" The brochure currently is being distributed to schools, preschools and Head Start programs in northern Michigan.

Russell Rothrock, MD, of Battle Creek volunteers his services to the Nursing Clinic of Battle Creek. He, along with a number of other volunteer physicians, provided the clinic with an opthalmoscope and otoscope for use at the clinic.

Paul A. Bruer, MD, of St. Clair, his wife, Kathryn, daughters Elizabeth and Abigail and sons Jeffrey and Stephen became interested in dyslexia when they realized that one of the children was dyslexic. In 1993 they started the St. Clair Center of the Michigan Dyslexia Institute to help other families in the area receive testing and evaluation without the hardship of traveling 80 miles to the nearest center. Kathryn works daily with volunteers and coordinates the activities of the center. Paul is involved in the testing and evaluation and family intake for the center, all done on a volunteer basis. They have obtained a match grant to train teachers all over Michigan.



1997 COMMUNITY SERVICE AWARD RECIPIENTS

CALHOUN COUNTY MEDICAL SOCIETY

John G. Bizon, MD, of Battle Creek, is recognized for his volunteer medical work at the School for the Deaf in Cavite in the Philippines, a site accessible only by helicopter or donkey. He currently travels to neighboring counties to participate in the health department's clinic for children with hearing impairment. Doctor Bizon, an otolaryngologist, also has been active with the Boy Scouts of America and serves on the District Committee. He received the "Distinguished Commissioner Award" and the "Director of Commissioners Service Award" for work in inner-city scouting. In 1995, Doctor Bizon and several other local physicians participated in "Mission Honduras," traveling there to a small clinic to provide much needed medical care.

DELTA COUNTY MEDICAL SOCIETY

Mary L. Cretens, MD, MPH, of Gladstone, is recognized for her volunteer medical work. Doctor Cretens has participated in a number of health care programs in Columbia, South America (Ship Hope), Panama (Jungle-Catholic mission outreach), San Blas Islands, St. Lucia, Honduras and on a South Dakota Indian reservation, all of which provide free medical care in areas that were lacking proper health care facilities.

GENESEE COUNTY MEDICAL SOCIETY

Vivian Lewis, MD, of Flint, earned the award for a wide array of community activities, beginning with her service on the pediatric staff of the Mott Children's Health Center from 1963-1970. She has been a strong advocate for children and families. Doctor Lewis has received many awards and has been a medical advisor for sev-



1997 COMMUNITY SERVICE AWARD RECIPIENTS

eral community organizations including the Easter Seal Society, the March of Dimes and the American Lung Association. She also has been a leader in many fund-raising campaigns. Doctor Lewis was the first woman and the first African-American president of the Genesee County Medical Society.

INGHAM COUNTY MEDICAL SOCIETY

Stephen R. Guertin, MD, of Lansing, is recognized for his work with children, specifically the Children's Miracle Network and providing indigent care through the neonatal center at Sparrow Hospital in Lansing.

JACKSON COUNTY MEDICAL SOCIETY

Arthur Wierenga, MD, of Jackson, is recognized for many years of medical missionary work dating back to 1966. Doctor Wierenga, an oph-

thalmologist, has not missed a trip to Guate-mala in the past 21 years. In 1996, he recruited and organized a predominantly Jackson-based team that not only facilitates medical care in Guatemala, but has also introduced agricultural programs, housing and literacy.

KENT COUNTY MEDICAL SOCIETY

Ralph Blocksma, MD, a retired member of the Kent County Medical Society, now living in Jacksonville, Florida, is recognized by his peers for his medical mission work. From 1949-1954, under the United Presbyterian Board of Foreign Missions, Doctor Blocksma helped establish the United Christian Hospital and became the Medical Director and Chief of Surgery. He also participated in some short term mission service between 1954 and 1978 in Thailand, Korea, Taiwan, India, Pakistan, Afghanistan, Oman, Bahrain, Lebanon, Ecuador, San Blas Islands,



Mary Cretens, MD, has volunteered her services in Columbia, Panama, the San Blas Islands, St. Lucia, Honduras and on an Indian reservation in South Dakota.



Vivian Lewis, MD, has been a longtime volunteer and medical advisor for Easter Seals, March of Dimes and the American Lung Association.



Stephen Guertin, MD, has long been involved with the Children's Miracle Network fundraising effort, and has provided a great deal of indigent care to underserved children.



1997 COMMUNITY SERVICE AWARD RECIPIENTS

Panama, Borneo, Nigeria, Malawi, Nicaragua and Liberia.

LIVINGSTON COUNTY MEDICAL SOCIETY

Roscoe Stuber, MD, of Howell, earned the award for a variety of community services. Doctor Stuber, a retired general surgeon, was recognized by the Howell Rotary Club as a Paul Harris Fellow for outstanding devotion to the demonstration of good will, peace and understanding. Other volunteer activity include service on the Healthy Livingston Program and Awards Committee, Livingston Community Hospice, chair of the Human Resource Committee of the First Baptist Church of Howell, Livingston County Catholic Social Services, Women's Resource Center and the Area Agency on Aging.

MACOMB COUNTY MEDICAL SOCIETY

Lawrence W. Loewenthal, MD, of Sterling Heights, is recognized for his volunteer efforts for Project Vision, a project he helped create, which donates medical equipment to hospitals in Israel as well as providing eye care to those in need. Since the inception of Project Vision, Doctor Loewenthal has made eight trips to Israel to provide care, teach modern procedures for cataract surgery and to help form an outpatient clinical facility. Project Vision now has requests from several other countries to help them establish similar projects.

MARQUETTE-ALGER COUNTY MEDICAL SOCIETY

Craig G. Stien, MD, of Marquette, earned the award for his efforts as a founding member of the board of the Marquette Community Foundation, where he currently serves as president.



1997 COMMUNITY SERVICE AWARD RECIPIENTS

He also served on the Marquette Board of Light and Power, and is a past vice president and president of that company. Doctor Stien, an otolaryngologist, has been the chief of staff and chairman of the building and grounds committee for the Upper Peninsula Medical Center and has been very active in youth hockey in the area.

MEDICAL SOCIETY OF NORTH CENTRAL COUNTIES

Ralph S. Steffe, MD, of Grayling, is recognized for a number of community activities, including providing free sports physical examinations for area students. A member of MSMS for 57 years, Doctor Steffe also was the medical director of the local Hospice of Michigan and the Skilled Care Facility at Mercy Manor in Grayling. He also has been quite active in his church and with the Milltown Festival.

Monroe County Medical Society

David J. Lieberman, MD, MPH, of Monroe, is recognized for his efforts assisting authorities after a recent fatal plane crash that occurred in Monroe County. Doctor Lieberman, Monroe County Medical Examiner, supervised the entire post-crash operation, setting up a physical plan to manage the on-site investigation. He also was in charge of identifying the victims and the coordination of the bereavement activities for family and friends.

Muskegon County Medical Society

Richard W. Peters, MD, of Muskegon, is recognized for a variety of community services, including Scoutmaster of a local Boy Scout troop for 12 years. During that time, the Boy Scouts of America awarded Doctor Peters the Silver Beaver Award, which is the highest award given to an adult in scouting. He has served on a num-



Arthur Wierenga, MD, left, has not missed a medical missionary trip to Guatemala in 21 years.



Lawrence W. Loewenthal, MD, helped to create Project Vision, which donates medical equipment to hospitals in Israel and treats needy patients there.



Richard Peters, MD, has received the Boy Scouts of America's highest award for his longstanding commitment as a local scoutmaster.

1997 COMMUNITY SERVICE AWARD RECIPIENTS

ber of committees in his local church, and recently accepted the post of County Medical Examiner. Doctor Peters, in taking this new position, indicated that he now would be "able to give something to the community."

OAKLAND COUNTY MEDICAL SOCIETY

Jaime V. Aragones, MD, of Rochester, and his family lead missions to overseas countries in order to provide ophthalmic services to people in need. His wife, Lou, and his two daughters have accompanied him on over 17 missions in the past. They bring medical supplies, medicines, surgical microscopes and the expertise necessary to perform surgeries under the most primitive conditions. The Aragones have served in many remote parts of the world including the Philippines, Mexico, Thailand and the Middle East.

SAGINAW COUNTY MEDICAL SOCIETY

Ramesh B. Cherukuri, MD, and Bala Srinivasan,

MD, both of Saginaw, are recognized for their efforts as part of a team of volunteers that traveled to India in 1996 to teach their counterparts in Bangalore the most up-to-date procedures in cardiovascular care. The team took with them seven crates of medical machines and surgery equipment to be used at a clinic to assist in providing cardiac and thoracic care to the poor.

St. CLAIR COUNTY MEDICAL SOCIETY

Gary G. Doss, DO, of Port Huron, is recognized for his work with area children. In 1996, Doctor Doss was given the "Friend of Kids" award by the Port Huron Area School District, an award given to an individual who has demonstrated a history of working for the benefit of children. He was chairman of the St. Clair County Medi-



1997 COMMUNITY SERVICE AWARD RECIPIENTS

cal Society Sports Medicine Committee that organizes an annual free 'sports screening' for students in Port Huron and Marysville schools. The committee screens about 1,200 athletes each year.

Washtenaw County Medical Society

Catherine J. Carroll, MD, of Ann Arbor, is recognized for her efforts and concerns with children's health and well being. Doctor Carroll was an advisor to the Ann Arbor School Board and was a charter member of *CASA* (Community Action on Substance Abuse). She also was a member of the SCAN (Suspected Child Abuse and Neglect) Team and the Washtenaw Council on Alcoholism, where she was particularly interested in, and an advocate for , recognition and therapy for children with Fetal Alcohol Syndrome and Fetal Alcohol Effects.

WAYNE COUNTY MEDICAL SOCIETY

Joseph M. Beals, MD, of Detroit, is recognized for his efforts to increase the WCMS's community involvement through the creation of an on-going project, the Webber School Health Center. Doctor Beals conceived the idea of a school-based health center for a medically underserved area in Detroit. The Center offers routine screening of all children in Webber Middle School for medical conditions along with referrals. In addition, volunteer dentists and dental assistants provide dental exams and referrals. The Center also provides health education projects for students.



Jaime Aragones, MD, and his wife and daughters have volunteered together in the Philippines and in Peru. Doctor Aragones is making plans for his 18th mission.



Doctor Ramesh Cherukuri (in sunglasses) and Bala Srinivasan, MD, (not pictured) taught techniques in cardiovascular care to colleagues in India.



Joseph M. Beals, MD, started a school-based health center for the medically underserved.





John H. Kopchick, MD, of Grand Rapids has participated in six missionary projects in the last years. Five of these projects involved urology consultation and surgery in Jamaica. He has also served as chief of the YMCA Indian Guides.



John Kopchick, MD has served with many medical missionary projects in Jamaica, and he and his family are active volunteers in their community.

Elizabeth Ann Sweeney, wife of **Patrick J. Sweeney, MD,** of Battle Creek, is very involved in promoting education in the community. She is also the current president of the Battle Creek Symphony Guild.

Genesee County Medical Society Alliance collects funds to provide new clothing for some of Flint's needy families.

Mark Thompson, MD, of Midland, was a volunteer health educator with the Midland Public Schools and a volunteer for community prostate screening. Rebecca, his wife, is involved with Big Brothers and Big Sisters of America and currently is serving on the Midland County BB/BS board of directors.

Fanny dela Cruz, MD, and **Victoria Navarra, MD,** of West Bloomfield spent nearly a week in February in the Philippines operating on adults and children. They repaired cleft lips, cleft palates and other congenital problems.

Thomas J. Alexander, MD, of Southfield is co-founder and physician advisor of the Tri-County Celiac Spru Society. A frequent lecturer at monthly meetings, Doctor and **Mrs. Alexander** have presented at national conferences in order to better educate its members in how to deal with their disease.

Oakland County Medical Society Alliance members have adopted a section of highway and have picked up trash along a two-mile stretch of road. Members also have volunteered at a "Docs and Jocks" run to raise money to combat domestic violence. On October 25 they will bake cookies for a North Oakland Medical Center free immunization clinic to be staffed by resident physicians.

Miriam Daly, MD, of Albion, volunteers for the Albion Resource Team, the Girl Scout Council, Red Cross blood drives, Calhoun County Red Cross, Albion Clinic Foundation, the First United Methodist Church, the Albion Rotary Club and the Calhoun County Community Health Assessment Steering Committee.

Todd N. Rosen, MD, of West Bloomfield provides psychiatric treatment to needy patients.

William A. Howard, MD, of Traverse City, has been the Boy Scout leader of Troop 34 in Traverse City for the past 20 years. Doctor Howard has helped more than 40 boys become Eagle Scouts over the years. He holds camping trips and high adventure trips such as sailing, skiing, biking or river rafting. He has been recognized by the local council as the recipient of the Silver Beaver Award for his active role in the area of scouting.



William Howard, MD, has been a volunteer leader in the Boy Scouts of America for 20 years.



The Tri-County Medical Society Alliance helps the Northwest Michigan Blood Program raise funds for a mobile drawing unit. They also have developed a health scholarship through Northwestern Michigan College, and have launched an Adopt-a-Family program that will assist families in need with groceries, utility bills and clothing.

Kenneth Jordan, MD, of Flint is a volunteer at the Genesee County Free Medical Clinic and is active in St. Paul's Episcopal Church. His wife, **Elizabeth,** is a volunteer fundraiser for the Genesee County Free Medical Clinic, on the board of directors for the Michigan Association for Educating Young Children, Foster-Grandparents to Genesee and Lapeer County, Blue Care Network and president of Mosaica Academy of Saginaw.

Kurt Haller, MD, an ophthalmologist from Kalamazoo, has provided free diabetic screening for a study conducted by the University of Michigan. He is on the Board of Directors of the SLD Center, a tutoring system for children with learning disabilities, is involved with the Kalamazoo Lions Club and he has coached soccer. **Cathy,** his wife, assists at the local school with the science lab, is a school room mother and Tiger Cub coordinator.

Steven Lessens, **MD**, of Shelby is a volunteer with the Westshore Symphony Board, the Rotary, Chamber of Commerce, Oceana Performing Arts Council, the Shelby School Board and the Shelby 2000 Development Committee. He also gives athletic physicals free of charge. **Sherry**, his wife, has been a member of the school board, and daughter **Jennifer** is a candy striper at Lakeshore Hospital.

Paul L. VanDenBrink, MD, has been an active volunteer for many years as deacon, elder and choir member of his church. Currently he is serving as treasurer of the Board of the Kalamazoo symphony and is on the board of Heritage Community. Kathleen, his wife has been a home room mother, library volunteer, Scout cookie chairman, chairman of the Kalamazoo Symphony Orchestra League and works with the Hospital Hospitality House of Southwest Michigan.

Louis Coriasso, MD, of Flint and nine members of his family were volunteers for the Buick Open, which donates thousands of dollars each year to local charities. Ann, his wife, was the 1994 Buick Open Volunteer of the Year and an assistant director of the Buick Open for eighteen years.



The Buick Open raises \$325,000 each year for charity, and Louis Coriasso, MD, and his family have volunteered on the course and in the office for many years.

Northern Michigan Medical Society Alliance is planning a charity tailgate party for "Make a Difference Day," complete with a pot-luck dinner and line dancing. Proceeds will go to local charities including the local Dyslexia center to fund a scholarship for needy students.

James Bour, MD, of Kalamazoo, volunteers by doing prostate cancer screening. His wife, Norma, is a member of the Curriculum Development Committee, family and consumer Sciences at Western Michigan University. She is a science volunteer, classroom helper and luncheon volunteer. She has worked with the American Heart Association and the local Dietetic Association as president and officer.



Lawrence Stieglitz, MD, plants and harvests sweet corn each year, and donates it to Kalamazoo food kitchens that serve the hungry and homeless



- **Daniel Garcia**, **MD**, his wife **Linda** and their four children, **Thomas**, **Christine**, **Katie**, and **Anna**, were one of *USA Weekend's* Top Ten "Make a Difference" honorees last year. Their family knocked on doors to collect \$5,000 to pay for a roof on a building to accommodate more homeless persons in Battle Creek.
- Nick J. Reina, MD, gives high school physicals on a voluntary basis, is a supporter of the Hispanic Council in St. Clair County, and is a member of the Board of Directors for Goodwill in St. Clair County. **Donna Reina**, his wife, is co-president of Indian Woods Girl Scouts, a soccer coach and a group leader volunteer for Odyssey of the Mind.
- **Thomas Stone, MD,** of Muskegon has been an active MSMS "legislative connection" for Muskegon County for years. Though he is now retired, he continues to maintain contact with other physicians in the community regarding legislative matters. **Nancy,** his wife, is a leader in raising funds for health promotion projects and for scholarships to local students who are pursuing health careers.
- **Tommy Stevens, MD,** is a volunteer member of the Greater Flint Task Force for Diabetes Mellitus and an executive committee member of the African American Physician's Association.
- **Richard McMurray, MD,** of Flint, and his wife, **LaMoine**, have participated in medical mission work in Honduras, and Doctor McMurray has been a ski patrol volunteer for 25 years. LaMoine has been a literacy volunteer as well.
- **Renato L. Raymundo, MD,** of Bloomfield Hills serves on medical missions overseas as an anesthesiologist for those in need of surgery.
- **Usha Raju**, **MD**, of Detroit, and her husband, **B. N. Raju** and **Lakshmi Kaza**, **MD**, are active participants in The Hunger Project. This project currently creates hunger-free zones in India, Bangladesh and four West African countries with high infant mortality rates.

- R. Rodrick Abbott, MD, an oncologist from Fenton is the president of the board of directors and an active participant for the Rap House, a drug rehabilitation center for youth. He was honored with the Clement Alfred Humanitarian Award for his efforts.
- **Abd Alghanem, MD,** a reconstructive surgeon from Flint, is an activist advocate opposing land mines.
- George Zureikat, MD, of Flint was given the Hurley Hero Medal of Honor for 1997 due to his unselfish, caring, and giving manner. He was also given the honor of being a 1997 Red Cross Hero, and in 1996 was the "Miracle Maker of the Year" for his work with raising funds for the Children's Miracle Network.



George Zureikat, MD, won the Hurley Hero Medal of Honor, among other awards, for his volunteer activities on behalf of sick children.





Amitabha Banerjee, MD, a pediatrician, is the president of the Nrityanjli Preservation of Indian Culture in the Flint area.

Fleming Barbour, MD, a retired ophthalmologist from Flint has been serving his community for years. As a member of the Christian Medical Society, he attended an annual medical mission to Honduras. Doctor Barbour also was an active participant in national YMCA World Services, the United Way, and Mott Children's Health Center.

Joseph Batdorf, MD, a family practitioner from Grand Blanc, is involved with drug awareness programs and is a past member of the board of directors for Services to Overcome Drug Abuse Among Teenagers.

Michael Boucree, **MD**, is active in the prevention of HIV/AIDS and drug abuse and received the Outstanding Young Men of the Year Award in 1981 for his efforts. Doctor Boucree practices internal medicine in Flint.

Delta County Medical Society Alliance is working on two volunteer projects: A scholarship program to teach pregnant teens how to take care of newborns; and a clothes closet for the Spouse Abuse Center.

Lila Esfahani, wife of **Ali Esfahani**, **MD**, of Grand Blanc, is an active volunteer for the YWCA.

Evelyn V. Golden, MD, a retired family practitioner from Flint, assists her community by volunteering at the YMCA, the Salvation Army, the Easter Seals Society and the Jewish Family Children's Services.

Saul Gorne, MD, a retired family practitioner from Flint has a long history of community service. He provided on site care for Flint strikers during the Depression, volunteered at the United Way and Jewish Family Children Services.

Kathy Blight, MD, a pathologist form Flint, is an active volunteer with the Genesee County Humane Society, and a volunteer for the Flint Institute of Music.

Samuel Dismond, **Jr.**, **MD** and his wife, **Jan**, a nurse, are active volunteers in their church and in their community. Among his many activities, Doctor Dismond has been very involved with the Genesee County Free Medical Clinic.



Doctor and Mrs. Samuel Dismond, Jr. are active volunteers.

Charles Thompson, MD, an internist from Flint is an active Rotary member, and active volunteer for the Mott Children's Health Center.

Edwin Gullekson, MD, a family practitioner from Flint, volunteers his time at the McLaren Child Evaluation Center, which helps sexually abused children.

John Herbert, III, MD, an OB/GYN from Flint, is an active Rotary member, chairing the Youth Exchange Program. His wife, **Nelda,** is active in community services, as a fundraiser for Planned Parenthood, and a volunteer for the Girl Scouts.

Stewart Hamilton, MD, an internist from Flint, is a volunteer for the Genesee County Free Medical Clinic.





- **Paul Karr, MD,** a Burton family practitioner, provides free medical care to patients at the Genesee County Free Medical Clinic.
- **Herry Nassar, MD,** of Grand Blanc is a nine-time participant in the Medical Mission to Honduras, and is a volunteer at the Genesee County Free Medical Clinic.
- **Joy Kommareddi**, wife of **Prasad Kommareddi**, **MD**, is the past chair and a volunteer for the Healing Hands 5K Run/Walk, a fundraiser benefiting the Genesee County Free Medical Clinic.
- **Billie Lewis, MD,** a Flint surgeon is an active volunteer with the United Way, American Cancer Society and the NAACP.
- **AppaRao Mukkamala, MD,** radiologist and **Sumathi Mukkamala, MD,** from Flint, are active members of the Chinmaya Mission West, a charitable Hindu organization and Seva Inc., a philanthropic organization based in Washington D.C.
- **Willys F. Mueller, MD,** a pathologist from Flint, is active in the prevention of HIV/AIDS, and volunteers with the Red Cross and the Child Death Review Team.
- **Jitendra Katneni**, **MD**, volunteers his time providing free medical care at the Genesee County Free Medical Clinic.
- **Brian Nolan, MD,** an internist from Flint, is a volunteer at the Genesee County Free Medical Clinic, and an advocate on child safety issues, including safety belt use.
- W. Archibald Piper, MD, is a retired plastic surgeon from Grand Blanc. He has been on medical missions to Russia, and is a volunteer at the Mott Children's Health Center, and the Genesee County Free Medical Clinic. His wife, Susan, is an active volunteer with the YMCA.
- **Jack Price, MD,** an OB/GYN from Flint, volunteers his time as the medical director for the Flint Community Planned Parenthood Association.

- **Lawrence Reynolds, MD,** a pediatrician from Flint, donates his time to the helping individuals and families in the Flint Sickle Cell Support Group.
- **Chris Rosenbaum**, wife of **Robert Rosenbaum**, **MD**, Flint, takes part in the Owosso Schools Host Program, which helps children learn to read.
- **Jagdish Shah, MD,** is an active participant in the building of a Hindu community in the greater Flint area. Doctor Shah is a internal medicine specialist in Burton.
- **Karen Sherrin**, wife of vascular surgeon **Frederick Sherrin**, **MD**, is a trainer for a combined Urban
 League and YWCA program called "Healing Racism."
 She travels throughout the midwest training other
 trainers.
- **Robert Soderstrom, MD,** a dermatologist from Flint, had been working to raise physician awareness for the environmental etiology of certain diseases. Doctor Soderstrom is part of several committees on environmental hazards.
- **Peter Thoms, MD,** of Flint, is a top fundraiser for the Christian Rural Overseas Program, and has served on several overseas medical missions.
- **Allen F. Turcke, MD,** is an active volunteer for the Genesee County Free Medical Clinic, and the Mott Children's Health Center. His wife, **Mary,** volunteers at the Leadership for Youth Program, and the Youth Reading Program.
- **Doctor and Mrs. Virgillo Villarreal** of Burton volunteer at the Spanish Speaking Information Center. Doctor Villarreal is a surgeon in Burton.

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plan to arrive 30 minutes early. Transportation will be provided. Seating is limited to 30 participants.

This course will familiarize physicians with personal computer hardware, software and common applications. Participants will be introduced to word processing, presentation program and the Internet. The course will be taught by professional computer instructors and expert physicians. To ensure each participant handson time, the course will be held in the Oakwood Health Services Corporation computer classroom, approximately one mile from the Hyatt Regency.

COURSE DIRECTOR: Nicholas J. Lekas, MD, FACP, Director, Internal Medicine Residency and Department of Medical Education, Oakwood Hospital, Dearborn

FRIDAY AFTERNOON. NOVEMBER 7, 1997

All afternoon courses run from 1:30 p.m. to 5:00 p.m. with a half-hour break.

IMMUNIZATIONS FOR A LIFETIME

PRESENTED BY: Michigan Academy of Family Physicians. This course will provide physicians with the current immunization recommendations for children, adolescents, adults and the geriatric population. Emphasis will be on recent changes. Information about immunizations for special populations, including international travelers and health care workers, will be included. Methods to improve effective immunization practices will be discussed.

COURSE DIRECTOR: Karen B. Mitchell, MD, Clinical Faculty, Providence Family Practice Residency, Southfield.

COLON AND RECTAL SURGERY

PRESENTED BY: Michigan Society of Colon and Rectal Surgery. This course will discuss different diagnostic tests, anorectal disorders, the role of genetics in colorectal cancer, advances in inflammatory bowel diseases and the role of laparoscopic colon surgery. This course is supported in part by a special bequest from the estate of Elizabeth T. Sladek.

COURSE DIRECTOR: K. Hamamdjian, MD, Assistant Professor of Surgery, Wayne State University School of Medicine.

ADDRESSING SEXUAL DIFFICULTY. DISTRESS AND DYSFUNCTION IN PRIMARY CARE PRACTICE

PRESENTED BY: Michigan Psychoanalytic Society and MSMS Committee on Concerns of Women Physicians. This course will focus on the crucial role of the primary care physician in dealing with sexual dysfunction. The etiology, diagnosis and treatment of various forms of sexual difficulty, distress and dysfunction will be reviewed. The counseling by the primary care physician of patients with commonly experienced forms of sexual distress will be discussed.

CO-DIRECTORS: Evangeline J. Spindler, MD, Past President of Michigan Psychoanalytic Society; Faculty at University of Michigan, Wayne State University and Michigan Psychoanalytic Institute

Cassandra M. Klyman, MD, Chair, MSMS Committee on the Concerns of Women Physicians, Past President of Michigan Psychiatric Society.

FOOD AND CHRONIC ILLNESS

PRESENTED BY: Michigan State University College of Human Medicine. This course will provide physicians, both generalists and specialists, with contemporary views on the role of foods in disease prevention and disease management for adults and children.

COURSE DIRECTOR: William B. Weil, Jr., MD, Professor Emeritus, Department of Pediatrics and Human Development, Michigan State University College of Human Medicine.

TECHNOLOGY SYMPOSIUM-Part 2

PRESENTED BY: Michigan State Medical Society Committee on Technology in Medicine. The MSMS Technology in Medicine Symposium is an educational forum for physicians who are interested in learning about the clinical applications of new medical technologies. In addition to educational sessions, the Technology in Medicine Symposium will feature a handson medical exhibit area, where many of the technologies featured in the symposium will be demonstrated.

COURSE DIRECTOR: David R. Rovner, MD, Assistant Dean of Technology, Michigan State University College of Human Medicine, East Lansing.

HANDS-ON INTRODUCTION TO **COMPUTERS AND THE INTERNET**

PRESENTED BY: Michigan State Medical

Society Committee on Technology in Medicine. This course will be conducted off-site. Please plan to arrive 30 minutes early. Transportation will be provided. Seating is limited to 30.

This course will familiarize physicians with personal computer hardware, software and common applications. Participants will be introduced to word processing, presentation program and the Internet. The course will be taught by professional computer instructors and expert physicians. To ensure each participant handson time, the course will be held in the Oakwood Health Services Corporation computer classroom, approximately one mile from the Hyatt Regency.

COURSE DIRECTOR: Nicholas J. Lekas, MD, FACP, Director, Internal Medicine Residency and Department of Medical Education, Oakwood Hospital, Dearborn.

SPECIAL EVENTS

Thursday, November 6, 1997
MICHIGAN OCCUPATIONAL AND
ENVIRONMENTAL MEDICAL ASSOCIATION
12:00 noon until 1:30 p.m. – Board Meeting

SPECIALTY SOCIETY PRESIDENTS

12:00 noon until 1:30 p.m. - Luncheon

MICHIGAN SOCIETY OF GENERAL SURGEONS 6:00 p.m. until 9:00 p.m.

MICHIGAN OCCUPATIONAL AND ENVIRONMENTAL MEDICAL ASSOCIATION CAREY PRATT McCORD DINNER

6:30 p.m. – Reception 7:30 p.m. – Dinner

UNIVERSITY OF MICHIGAN MEDICAL SCHOOL ALUMNI (INVITATION ONLY)

6:30 p.m. - Reception and Dinner

MICHIGAN ORTHOPAEDIC SOCIETY

Executive Committee Meeting -2:00 p.m. Reception -6:00 p.m. Dinner w/Speaker -7:00 p.m.

Friday, November 7, 1997 LEGISLATIVE BREAKFAST

7:00 a.m. until 8:15 a.m.

MSMS COMMITTEE ON CONCERNS OF WOMEN PHYSICIANS

12:00 noon until 1:30 p.m.

MSMS WOMENS' CAUCUS

5:00 p.m. until 7:00 p.m. - Reception

WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE ALUMNI

5:00 p.m. until 7:00 p.m. - Reception

MICHIGAN SOCIETY OF COLON AND RECTAL SURGEONS

6:00 p.m. – Reception 7:00 p.m. – Dinner

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Doctors, please take a moment to thank our patrons for their continuing financial support of the MSMS Annual Scientific Meeting. It is their help that makes it possible for us to improve the program each year, and to keep registration costs low for our members!

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Information, education at your fingertips

MSMS/MPMLC debut new internet site

By Frederick W. Minkow, MD and Thomas C. Payne, MD

ave you missed an interesting conference you wanted to attend because of the complica-tions of the paper trail in your office? Are you wondering if your assistant faxed the registration form, or if you remembered to ask your assistant to do it? Have you had a risk management guestion nagging you for awhile, but can't find the time to make the call to research the answer?

We have some solutions to these problems. Information about our risk management programs will now be easy to access on the internet from either the MSMS or MPMLC home page. Not only will program information be available, but one can register on-line. This capability will enable physicians to quickly plug into ongoing risk management programs offered by MSMS and MPMLC.

Patients bringing us information that they find on the internet. This is the future of communication. If our membership can become more comfortable using e-mail, there is less chance for error and a more efficient way of getting information out. This option of making an in-

quiry by e-mail is so much more convenient.

Yes, the time has come. MSMS and MPMLC have caught up with the future and simultaneously launched internet sites for getting the word out about their risk management services. Risk management educational program infor-

Risk Management Training

By Colleen Horton

MSMS and MPMLC have joined together to offer physicians and their staffs educational programs that focus on reducing the risk of professional liability claims. "The Medical Malpractice Trial Experience," will be offered on December 4 in Dearborn and December 11 in Port Huron, and at WMU Regional Center, Grand Rapids, is designed to provide physicians with an understanding of trial preparation through re-enactment of an actual trial. "Closed claim reviews" also are offered October 7 in Saginaw, October 14 in Marquette, October 15 in Escanaba, and October 28 in Grand Rapids.

Another educational seminar, "Negotiating Safe Passage in a Changing Healthcare Environment," is offered October 21 in Flint and November 18 in Troy. Its focus is on responding to current trends in litigation and the transition to managed care which place physicians at risk. Seminars are scheduled throughout the state and are open to all physicians, non-MSMS members as well as members. Non-CME credit short courses providing an introduction to risk management or exploration of particular topics are available on request for Michigan medical students and residents. CME credits can be arranged for small-group discussions led by experts focus on subjects meet specific needs.

For information about CME credits or to register for any of the above seminars, call Darla Brandon at MSMS at (517) 336-5769 or e-mail to dbrandon@msms.org/

The author is MSMS Communications Assistant.



mation is now at your fingertips. Just dial into the MSMS or MPMLC home page and go from there. Links from MSMS to MPMLC and vice versa exist to make it easy to check out both sites. True to form, the close relationship between the two organizations allows their programs to complement each other and offer more variety to member physicians. The MPMLC site also provides an overview of seminars and credits available in Michigan and other states. In addition, the MSMS site permits on-line registration. Both sites provide the ability to browse through an array of frequently asked questions (and answers, of course). And finally, there is an e-mail link to the risk managers (Ask Our

Risk Management Expert) so that you can pose that nagging risk management question and receive an answer, when it's convenient for you. Check it out. The honor of your presence is requested...on-line: www.msms.org or www.mpmlc.com/

Thomas C. Payne, MD, is former MSMS President and current Chair of the Risk Management Committee; Frederick W. Minkow MD, is Chair of the Risk Management Committee at Michigan Physicians Mutual Liability Company (MPMLC).

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MSMS

October

- 7. MSMS/MPMLC Closed Claim Review. Location: Holiday Inn, Saginaw. Contact: Darla Brandon, (517) 336-5769.
- 10, 11, Meeting of the Western Michigan Urological Society. Crys-Mountain Resort. tal Thompsonville. Contact: Lori, (616) 947-3516.
- 14, MSMS/MPMLC Closed Claim Review. Location: Ramada Inn. Marquette. Contact: Darla Brandon, (517) 336-5769.
- 15, MSMS/MPMLC Closed Claim Review. Location: Days Inn, Escanaba. Contact: Darla Brandon, (517) 336-5769.
- 15, MSMS/MPMLC Risk Management Seminar. "Radiology." Location: Holiday Inn Gateway Centre, Flint. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 16, MSMS/MPMLC Risk Management Seminar. "Physician Criminal Exposure." Location: MPMLC Headquarters, East Lansing. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 21, MSMS/MPMLC Seminar. "Negotiating Safe Passage in a Changing Healthcare Environment." Location: University Club, Flint. Contact: Darla Brandon, (517) 336-5769.

- 25, MSMS/MSMSA "Michigan Physicians and Their Families Make a Difference Tailgate for Charity." Location: Spartan Stadium, East Lansing. Contact: Sheri Greenhoe, (517) 336-7603.
- 28, MSMS/MPMLC Closed Claim Review. Location: Amway Grand Plaza, Grand Rapids. Contact: Darla Brandon, (517) 336-5769.

November

- 5-7, MSMS Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. Contact: James Tarrant at MSMS at (517) 336-7591.
- 12. MSMS/MPMLC Risk Management Seminar. "Physician Criminal Exposure." Location: Holiday Inn Gateway Centre, Flint. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 13, MSMS/MPMLC Closed Claim Review. Location: Fetzer Center, Kalamazoo. Contact: Darla Brandon, (517) 336-5769.
- 17, MSMS/MPMLC Risk Management Seminar. "Anatomy of a Lawsuit." Location: Double Tree Hotel, Novi. Contact: Liz Treanor. (810) 748-0465, ext. 288.
- 18, MSMS/MPMLC Seminar. "Negotiating Safe Passage in a Changing Healthcare Environment." Location: MSU Management Education Center, Troy. Contact: Darla Brandon, (517) 336-5769.

- 18, MSMS Internet Training Seminar. Location: Battle Creek. Contact: Jody Jodway at MSMS at (517) 336-5604.
- 19, MSMS Board of Directors. Location: MSMS Headquarters, East Lansing. Contact: Irene Frost, (517) 336-5734.
- 20, MSMS/MPMLC Risk Management Seminar. "Emergency Services." Location: Holiday Inn Airport, Kalamazoo, Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 20, MSMS/MPMLC Closed Claim Review. Location: St. Joseph Hospital East, Mt. Clemens. Contact: Darla Brandon, (517) 336-5769.
- 21, MSMS Internet Training Seminar. Location: Roscommon. Contact: Jody Jodway at MSMS at (517) 336-5604.
- 22, MSMS Internet Training Seminar. Location: Flint. Contact: Jody Jodway at MSMS at (517) 336-5604.
- 29, MSMS Internet Training Seminar. Location: Lansing. Contact: Jody Jodway at MSMS at (517) 336-5604.

December

- 4, MSMS Internet Training Seminar. Location: Grand Rapids. Contact: Jody Jodway at MSMS at (517) 336-5604.
 - 11, MSMS Internet Training

Seminar. Location: Auburn Hills. Contact: Jody Jodway at MSMS at (517) 336-5604.

AMA

December

4-10, 1997 AMA Interim Meeting. Location: Dallas, TX. Contact: Judy Marr at MSMS at (517) 336-5744.

SPECIALTY SOCIETIES

October

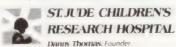
- 3, Michigan Department of Community Health Regional Immunization Conference. Location: Lansing. Contact: Rosemary Franklin, (517) 355-9485.
- 4, "Every Woman's Health Forum." Location: Mawby Education Center, Battle Creek. Contact: (616) 966-1453.
- 14, Michigan Department of Community Health Regional Immunization Conference. Location: Boyne Mountain. Contact: Rosemary Franklin, (517) 355-9485.
- 16, Michigan Department of Community Health Regional Immunization Conference. Location: Marquette. Contact: Rosemary Franklin, (517) 355-9485.
- 31, Michigan Department of Community Health Regional Immunization Conference. Location: Ypsilanti. Contact: Rosemary Franklin, (517) 355-9485.

November

- 4, Michigan Department of Community Health Regional Immunization Conference. Location: Ypsilanti. Contact: Rosemary Franklin, (517) 355-9485.
- 7-9, Michigan Association of Medical Examiners Annual Meeting. Contact: Melissa Wiegand at MSMS at (517) 336-7586.
- 21, Michigan Committee for Prevention of Child Abuse. Location: MSMS headquarters. Contact: Jean Smith at MSMS at (517) 336-5604.



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MSMS members run for office

Physician candidates DeWeese and Artinian

By Donna Kondek

The wellsprings of medicine and politics are one and the same, according to one mid-Michigan physician.

"It's really caring about people," declares Paul DeWeese, MD, a 41-year-old emergency room doctor and candidate for state representative. However, that philosophy explains only one of DeWeese's reasons for campaigning for the 67th District seat in the 1998 Republican primary.

Deciding to run for office

Doctor DeWeese, a Williamston resident, is one of two state physicians who have officially declared they are running for office next year. The other, Gary Artinian, MD, wants to be Michigan's next governor; he vows to stay in the race even if current governor and fellow Republican John Engler runs for a third term.

> "I started thinking about running when Governor Engler originally announced he would never run again," says Doctor Artinian, a Bloomfield Township cardiologist who has been active in Republicanparty politics for 30 years, mainly as a fund-raiser.

> Other factors in Doctor Artinian's decision to run include his long-standing concern about social problems that divide people, as well as the public reaction to a

monograph he wrote critiquing the Clinton health care plan. The monograph generated mail from many states and was circulated widely, discussed on talk shows, and reproduced on the Web. "Interestingly, I realized the strength of ideas and the power of being able to write them down clearly," he explains.

A number of circumstances also added up to convince Doctor DeWeese to run, including his abiding, deep interest in public policy and international affairs. Although he has never run for public office, Doctor DeWeese is founder and chairman of TEACH Michigan, an organization that has helped form Michigan's charter school law and new charter schools.

"My experience over the last eight years, being at the center of the education-reform debate, was influential," Doctor DeWeese notes, "in terms of my understanding of how the system works, interest groups and how they impact public policy, and how laws are changed."

In addition, term limitations opened up the seat for which Doctor DeWeese is running, making the decision easier for him from a practical standpoint.

Plan of action

Unlike Doctor DeWeese, Doctor Artinian has experienced a statewide election before. having won an eight-year term on the Wayne State University board of governors in 1984. He admits that was mainly a coattail victory, during an election in which analysts say Ronald Reagan's landslide carried into their posts every Republican in Michigan who was running for an education-related seat.

Holding public office is similar to practicing medicine, Doctor DeWeese says. "My task as a physician is to listen and understand, diagnose what's going on and prescribe therapy. That's what a politician's role is too. The physician prescribes drugs, dietary changes and the like; the politician changes laws. As a physician, I generally care about individual people and their well-being. As a politician, I care about people in the context of their living in society."

Continued medical involvement

How do patients feel about their physician running for office? So many of Doctor Artinian's have told him they will not campaign on his behalf because they depend on him to take care of them. "If I win, I could set up a blood-pressure cuff and exam table in the governor's offices," Doctor Artinian guips. "Actually, I've selected a couple of people who would fill in for me [in the practice] for four or eight years. I



Doctor Artinian

have very loyal patients."

Doctor DeWeese plans on working part-time in the emergency room at Eaton Rapids Community Hospital and Owosso Memorial Healthcare Center at night and on weekends, setting a schedule that wouldn't interfere with his legislative duties. A self-described citizenpolitician, he believes the part-time work will keep him grounded in the community.

Before, people held office as a career. DeWeese explains. "You can't do that anymore, and there's no job you can just leave for six years and plop back into. So we'll see a lot more professionals in office who'll maintain a practice outside the legislature."

Political Outlook

Both candidates perceive the public's impression of politics and politicians similarly. Doctor Artinian, 53, believes many people think government is degenerating or devolving and says the public pays for the fiscal mismanagement of leaders who seem to escape accountability.

Doctor DeWeese characterizes society's view as a tremendous cynicism about the role of government and public service that comes out of many different experiences in our national life, citing corruption at high levels of government and a sense that politicians and candidates are beholden to monied and special interests, as opposed to doing the hard work of representing the welfare of society at large.

Doctor DeWeese has been meeting voters by going door-to-door and has spoken before some civic groups. He strives to listen carefully to people he meets, to tap into their common sense, and attract non-voters back to the voting booth.

Doctor Artinian says his campaign is getting good vibes and receiving donations, some as small as \$2 but averaging around \$65, from around the state in response to his announcement, ads, and mass mailings (some to physicians). "A number of state legislators have shown an interest in working on his campaign if Gov. Engler drops out," he adds. He claims he'll spend less on his campaign than will other gubernatorial candidates. Doctor Artinian also says, to maintain his focus on people as patients, he won't be getting money from special interest groups like insurers or unions, and by not taking it he'll actually help raise money for opponents who will.



Doctor DeWeese

Campaign agendas

He can be elected because he has been elected before, has supporters (including many retired patients) around the state and is willing to go out to talk to people, look at them eyeball to eyeball, and answer any question put to him.

If elected, Artinian says he would cut the governor's staff while opening two additional governor's offices (in Grand Rapids and the northern Lower Peninsula). He'd spend part of the week at each and be open to the public by appointment. He says he won't spend time in Washington. He will try to relocate some state offices throughout Michigan to be closer to the populations they serve and help improve local tax bases.

A strong opponent of managed care, because he believes it emphasizes the bottom line more than the patient, Doctor Artinian wants to engineer a prescription coverage program for all senior citizens. He would work to privatize Medicaid by using the funds instead to buy private health insurance for the poor in a deal he'd negotiate with an insurer himself, and he'd make the non-compensated services that doctors provide to the poor partly tax-deductible to encourage them to provide more. He wants to remove mandates for selling health insurance and ensure the deductibility of health insurance premiums for small businesses, which would then be more likely to offer insurance to employees.

"There are no physicians in the House and it's important there be one who can intuitively understand the impact of current legislation on the daily practice of medicine ... and inform **legislative** colleagues about the impact of these issues."

Doctor Artinian has no aspirations for higher office. "I won't take the presidency, even if they offer it, he jokes. I hate to leave Michigan."

Doctor Artinian also says, to help create jobs, he would reduce state employees' workweeks to four days and phase out the single business tax, replacing it with a one-cent increase in the state sales tax. To decrease crime, he'd like to dispense methadone or its equivalent to drug addicts, who by registering in his program would be brought into close contact with health care professionals who could help them overcome their addictions.

Doctor DeWeese believes he can be elected because the 67th District is almost 60 percent republican, he has begun campaigning before anyone else, and he has a well-defined philosophy that helps him analyze and understand issues and come to the public with a coherent sense of what society should try to accomplish. He is stressing three major campaign themes: community, civility and compassion.

"I believe in enlarging the sphere of private liberty and decreasing the power and influence of government, in general, as a Republican," Doctor DeWeese says. "But because of my exposure to vulnerable people, I also believe there's an important role the public has in addressing the vulnerability of people. That is, what government does or doesn't do can exacerbate or ameliorate the vulnerability of people."

Doctor DeWeese would work to ensure every child a world-class education and provide health insurance to all working people without creating a government-run entitlement system. He anticipates creating a transition from current welfare policy (a disaster, and immoral), from dependency without a call to responsibility, to society making a pathway of hope, where we harness the energy, vision and capability of people to make a better life for themselves.

Calling it a scandal that physicians have generally opted out of involvement in politics, Doctor DeWeese acknowledges that physicians are generally financially comfortable, private people who may be uncomfortable with public advocacy. He thinks that some, due to their prestige, income and intellect, may even be perceived as arrogant or condescending characteristics he labels ineffective in public life. Both Doctors De Weese and Artinian concede that the nature of attorneys' work and their familiarity with law-making enable them to run for and serve in office more easily.

Doctor DeWeese contrasts the inadequate political influence of doctors with the influence of organized groups like the state's trial lawyers. who are mobilized, knowledgeable and involved and put their money where their interest lies, to the detriment of the public.

"There are no physicians in the House," Doctor DeWeese notes, "and it's important there be one who can intuitively understand the impact of current legislation on the daily practice of medicine ... and inform legislative colleagues about the impact of these issues."

Because of his involvement in school issues, Doctor DeWeese has already experienced controversy and exposure to the media. "I'm not sure anyone ever gets prepared for that," he says. "If you get attacked in the press, I think it's something you have to deal with as it comes. My family is supportive of me running." He will not use his family politically, he adds.

If elected, Doctor DeWeese intends to run for more than one term. He says this office would not be an automatic steppingstone to higher office, but he would explore additional opportunities once he feels he has demonstrated his leadership capabilities and is contributing to the public welfare.

As for Doctor Artinian's family, they are supportive but they're controlling their enthusiasm. he laughs. My wife's not overjoyed, he says of Karen, to whom he's been married nearly 30 years. But she is a great asset, a very articulate and pleasant person.

Doctor Artinian has no aspirations for higher office. "I won't take the presidency, even if they offer it, he jokes. I hate to leave Michigan."

The author is a Lansing-area freelance writer.

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Physician Responsibility and Accountability

Future legislation may clarify issues

By Roger Kahn, MD



urrently there are a number of medical issues before our state legislature. This view-point is about a common theme that runs through much of this proposed legislation: public responsibility, accountability and the public good in a civil society.

Those providing telemedicine services, like over-the-phone xray interpretation have no Michigan licensure requirement if they reside outside of our state. This leads to unclear accountability and unclear diagnostic standards for their services.

Denial of proposed service by an insurer utilization reviewer clearly chills a patient's desire for that service. Yet those denying the service may not be expert in the involved medical area. When their decisions lead to patient harm or death, the reviewers refuse to accept responsibility for their decisions. Common examples would be denying second opinions or repeat testing. Such low quality review is not in the public interest. Reviewers should be responsible and accountable. These examples show areas where government needs to act.

We now are seeing a bill designed to allow independent prescription authority for advanced practice nurses (APNs). Current law allows APNs to prescribe drugs only through collaboration with a licensed physician. It is argued that APNs are qualified and trained to diagnose and treat virtually all common illnesses, independent of a physician.

It is argued that APNs receive at least as much pharmacology classroom training as doctors. Furthermore the services of midwives, anesthetists and nurse practitioners are considerably less expensive than physician services.

First of all, if the supervising physician fails in his responsibility to in fact supervise an APN that is not a good reason to remove supervision. It may, however, be a good reason to remove the supervisor. Next, classroom training is only the start to physician education. MDs are not approved for li-

cense in Michigan until completing two postgraduate years of directly supervised training (about the same time as the total advanced training that APNs purportedly receive in diagnosis and treatment). Meeting that accountability standard ought to prevent harm to the public. This is an important issue as the current proposed legislation doesn't define who qualifies as an APN or what their training must include or their level of continuing medical education responsibility. It would just add them to the list of legal prescribers. And, so again I am concerned for public accountability, responsibility and the public good. This time, however, the concern is generated by a proposal to remove existing public safeguards. The MSMS-MOA Scope of Practice Task Force has established the mission of reviewing and analyzing the education, training and background of allied and alternative health professionals with the objective of developing a document that can be used to inform physicians, health care professionals, lawmakers and the public.

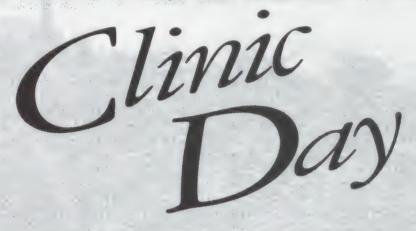
Part of a civil society is the public discussion of issues such as these. It also includes informing your legislators of your concerns and ideas. If we do that, then proposed legislation may be improved. I urge you to contact your state representative and senator on these issues.

The author is a Saginaw cardiologist.

Editor's note: For a full discussion of the issues of telemedicine, see the September Michigan Medicine cover story. Portions of that month's coverage also are available on the MSMS homepage at http://www.msms.org/



The medical staff of St. Joseph Mercy-Oakland celebrates its 40th anniversary of Clinic Day at the Troy Marriott, Troy Michigan on Wednesday, November 12, 1997.



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"Bariatric Surgical Intervention"
George S. M. Cowan, M.D.,
General Surgeon, University of Tennessee Medical Group,
Obesity Wellness Center

"Evaluation of the Sleepy Patient" and "Medical Management of OSA" Clete Kushida, M.D.

Director of Stanford Center for Human Sleep Research, Staff Physician and Clinical Instructor at Stanford Sleep Disorders Center, Stanford University

"Fat and Less Fat - Medical Management of Obesity"

Robert W. Lash, M.D.
Assistant Professor of Internal Medicine,
Division of Endocrinology and Metabolism,
Department of Internal Medicine,
The University of Michigan Medical Center

"Fat and More Fat - Epidemiology, Pathogenesis and Genetics of Obesity" James Levine, M.D., Ph.D. Division of Endocrinology, Mayo Clinic

"Surgical Evaluation of OSA/ENT Approach"
Samuel Mickelson, M.D., F.A.C.S.
Atlanta Ear Nose and Throat Association

"Morbidity and Mortality Associated with OSA"

Kingman P. Strohl, M.D.

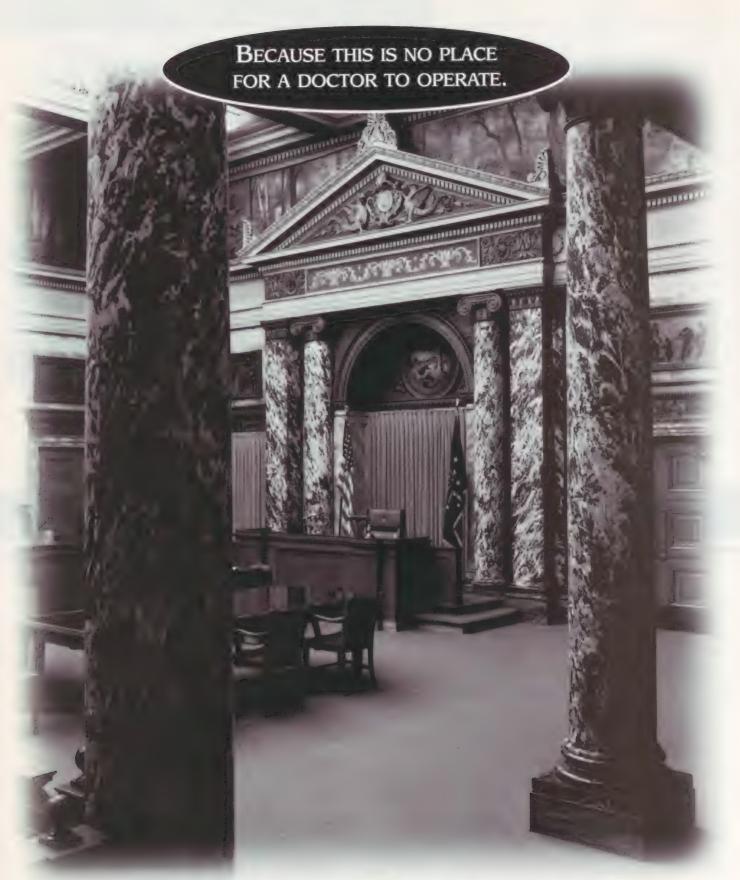
Professor of Medicine and Director of the Center
for Sleep Disorders Research at

Case Western Reserve Veteran Affairs Medical Center

"Surgical Evaluation of OSA/Oral-Maxillofacial Approach" Peter D. Waite, M.P.H., D.D.S., M.D. Professor and Chairman, Department of Oral and Maxillofacial Surgery, The University of Alabama at Birmingham

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NEWS MAKERS

Lowell M. Weiner, MD, of Flint is the new vice president and corporate medical director of HealthPlus of Michigan. Doctor Weiner, who is a graduate of the University of Michigan Medical School, also will serve as chief medical spokesperson and primary physician officer for the corporation.



The National Committee for Quality Assurance Practicing Physicians Advisory Council (NCQA) cently appointed

Kathleen L. Yaremchuk, MD, to the Council. As a council member. Doctor Yaremchuk, a otolaryngologist with Henry Ford Hospital, will identify areas for improvement in managed care systems. Her input will help ensure that NCQA policy proposals are physician-friendly.

David Rosenberg, MD, of West Bloomfield was honored with the A.E. Bennett Research Award by the Society of Biological Psychiatry. Doctor Rosenberg, an associate professor of Psychiatry and Behavioral Neurosciences at Wayne State University, received the award because of his exemplary contributions to the field of biological psychiatry. His research has helped to identify the portions of the brain that do not function properly in obsessive-compulsive disorder.

Kimberly Dawn Wisdom, MD, was recently praised by the Michigan Affiliate Chapter of the American Diabetes Association for her role in establishing a Detroit chapter. Doctor Wisdom, of Southfield, treats diabetes complications as an emergency department physician at Henry Ford Medical Center-Fairlane.

Edward Krull, MD, of Grosse



Pointe, recently received the Professional Achievement Award from the Wavne County Medical Society. Doctor Krull was

honored for his contribution to dermatology and his internationally recognized leadership role in the field. He has retired as Dermatology chairman but will continue as a staff dermatologist in the Henry Ford Health System.

Jeffrey D. Forman, MD, was selected by the National Cancer Institute for its Prostate Cancer Progress Review Group. Doctor Forman, of Detroit's Karmanos Cancer Institute, currently directs the Institute's Genitourinary Multispecialty Practice and serves as the Hartmann Professor of Radiation Oncology at the Wayne State University School of Medicine. As a member of the Progress Review Group, Doctor Forman will consider the scientific issues facing prostate cancer, and outline the nation's longterm research plan to fight the disease.

Peter McCullough, MD, MPH, has



been named director of Cardiovascular Informatics and associate director of the Center for Clinical Effectiveness at

Henry Ford Health System. Doctor McCullough, of Northville, will work with two other physicians in a joint effort to develop a comprehensive cardiovascular information system. In addition, he will devote his time to the care of heart patients at Henry Ford Hospital. Doctor McCullough currently serves as a member of the American Heart Association's Council for Epidemiology and Prevention.

The Field Neurosciences Institute in Saginaw has named Kenneth J. Gaines, MD, medical director of the Institute. Doctor Gaines, a Saginaw neurologist is a member of the American Association of Electromyography and Electrodiagnosis, the American Society of Neuroimaging and the International Society of Hypertension in Blacks. He is also a fellow of the stroke council with the American Heart Association.

St. Joseph Mercy Hospital—Ann Arbor, recently appointed Stanley R. Strasius, MD, interim chief of staff. Doctor Strasius, an Ann Arbor gastroenterologist, was vice chief of staff prior to this appointment, and also served on several hospital committees. He is also president of Huron Gastroenterology Associates, PC.

Kevin A. Kelly, Managing Director



of MSMS, was recently elected to the Board of Directors of the American Association of Medical Society Executives

(AAMSE) for a two-year term. Mr. Kelly serves on the planning committee for AAMSE's New Medical Executive Institute and on the AAMSE Foundation Board of Trustees. AAMSE provides its members with educational and networking opportunities and acts as a conduit for information on general association and medical society management topics.

OBITUARIES

Robert Sinanian, MD, died April 8. He was 58. A Kalamazoo emergency medicine and general practitioner who graduated from the University of Michigan Medical School, Doctor Sinanian was a member of MSMS and the American College of Emergency Physicians.

Robert J. Mearin, MD, died April 10. He was 90. A Frankfort psychiatrist and a graduate of Syracuse University Medical School, Doctor Mearin was in the U.S. Navy Medical Corps, was a New York State University Psychiatric Faculty member and served as a committee member for the American Psychiatric Association and New Jersey Neuropsychiatric Association. He was a member of the American Association of Medical Psychiatry, World Federation of Mental Health and MSMS.

Wendall H. Rooks, MD, died April 20. A Grand Rapids psychiatrist, who graduated from the University of Michigan Medical School, Doctor Rooks was a member of MSMS and the American Psychiatric Society.

East Lansing otolaryngologist, Robert A. Holmes, MD, died April 24. He was 58. A graduate of Temple University School of Medicine, Pennsylvania, Doctor Holmes was on the faculty at the College of Human Medicine at Michigan State University. He was a member of the American Academy of Otolaryngology, American College of Surgeons and MSMS.

Sunilendu N. Ganguly, MD, died April 28. He was 57. A Detroit internist and graduate of the Medical College of Calcutta, India, Doctor Ganguly was a member of Wayne County Medical Society, MSMS and the AMA.

The 1970-71 President of Livingston County Medical Society, Karol J. Granowski, MD, died April 1997. He was 78. A radiologist from Howell, he graduated from Jagiellonian University, Poland. Doctor Granowski was a member of the American College of Medical Imaging, AMA and MSMS.

Theodore M. Mattson, MD, died on May 4. He was 78. Doctor Mattson was a Birmingham general surgeon who graduated from the University of Michigan Medical School. He was a member of Oakland County Medical Society, MSMS and the AMA.

Leonard Birndorf, MD, died on May 7. He was 82. An Orchard Lake family practitioner, Doctor Birndorf was a graduate of Wayne State University Medical School. He was a member of Wayne County Medical Society, MSMS and the AMA.

President of the Wyandotte General Hospital medical staff in 1972, Fred R. Severyn, MD, died on May 8. He was 65. A graduate of Loyola Medical School, Illinois, Doctor Severyn was member of the AMA. MSMS and the Michigan Society of Obstetricians and Gynecologists.

The 1938-39 and 1946-47 Lenawee County President, Lowell E. Blanchard, MD, died June 10. He was 93. A Hudson general practitioner, Doctor Blanchard graduated from the University of Michigan Medical School. He was a member of MSMS and the AMA.

Joseph M. Manoharan, MD, a Grand Blanc internist, died June 18. He was 56. A graduate of University of Ceylon, Doctor Manoharan was a member of MSMS and the AMA.

Richard W. Welk, MD, an anesthesiologist from Midland, died in June 1997. He was 65. A graduate of Kansas University Medical School and a US Army Veteran, Doctor Welk was a member of the Midland County Medical Society, MSMS and the AMA.

Forest Dodrill, MD, a Detroit thoracic and cardiovascular surgeon. died June 23. He was 95. Doctor Dodrill was able to perform the world's first successful open heart surgery in 1952 after developing a mechanical heart pump. He was a Board of Trustee for the American Heart Association, past-president(1957-58) of the Michigan Heart Association, and was also a member of AMA and MSMS.



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Paul J. Antal, MD, Manistee Wendy L. Bauer, MD, Kalamazoo Nicolette P. Baumgartner, MD, Kalamazoo

Paul A. Berkowitz, MD, Ann Arbor Michael W. Berneking, MD. Portage

Matthew L. Boulton, MD, Ypsilanti Maria Bradshaw, MD, Saline Nicolaas W. DeWette, MD. Kalamazoo

Mario J. DeMeireles, MD, Ann

Jennifer M. Eschbacher, St. Clair Shores

Tim A. Fischell, MD, Kalamazoo Keith A. Heslinger, MD, Flint Marcia L. Johnson, MD, Kalamazoo

Robert A. Krasnick, MD, Warren Nancy J. Lewandowski, MD, Ann Arbor

Paul J. O'Brien, DO, Flushing Saadia K. Rahman, MD, Kalamazoo

Karen M. C. Rhodes, DO, Flint Mahesh Sharma, MD, Flint Andrew Szefler, MD, Flint Julie Xeras, MD, Portage

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DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: Danial Hopkins, MD, 225 Gardenia, Royal Oak, MI 48067

Action, Date Taken: License Summarily Suspended, 6-20-97

Reason: Mental/Physical Inability to Practice

Name: Arthur P. Bober, MD, 25545 Tweed, Franklin, MI 48025

Action, Date Taken: License Suspended—6 mo. & 1 day, Summary Suspension Dissolved 7-13-97

Reason: Substance Abuse

Name: Amnat Chandra, MD, 28477 Hoover Rd., Warren, MI, 48093

Action, Date Taken: License Suspended—6 mo. Probation—1 yr. Commencing at the end of the suspension period, Fine—\$5,000, 7-18-97

Reason: Negligence/Incompetence

Name: Hector L. Mulero, MD, 15777 Northline Rd., Southgate, MI 48195

Action, Date Taken: Reprimand, 6-18-97 Reason: Violation of General Duty/Negligence

Name: Rosemarie Blosen, MD, 20070 E. River Rd., Grosse Ile, MI 48138

Action, Date Taken: Reprimand, Fine—&1,000, Probation—2 yrs., 6-27-97

Reason: Failure to Meet Continuing Education Requirements

Name: Stanley J. Woollams, MD, 3443 Daleview, Ann Arbor, MI 48105

Action, Date Taken: Cease and Desist, 6-11-97 Reason: Unlicensed Practice of Medicine

Name: Elmer D. Powers, DO, PO Box 170, Grand Haven, MI 49417

Action, Date Taken: Reprimand, Fine—&1,000, Probation—2 yrs., 6-24-97

Reason: Failure to Meet Continuing Education Requirements

Name: Joseph E. Oesterling, MD, Department of Urology, University of Michigan, 1500 E. Medical Center Dr., Ann Arbor, MI 48109

Action, Date Taken: License Summarily Suspended, 8-6-97

Reason: Criminal Conviction

Name: Bonnie M. Warmack, DO, 14438 W. McNichols, Detroit, MI 48235

Action, Date Taken: License Summarily Suspended, 7-

Reason: Criminal Conviction—Drug Related

Name: Ashwin H. Shah, MD, 730 N. Macomb, Suite 419, Monroe, MI 48162

Action, Date Taken: Probation—1 yr., Fine \$1,000, 8-16-97

Reason: Violation of General Duty/Negligence

Name: Gerald Rakotz, MD, 27450 Schoenherr, Warren, MI 48093

Action, Date Taken: Fine \$5,000, 8-15-97 Reason: Violation of General Duty. Negligence

Name: Robert L. Chadwick, DO, 4945 Hardwoods Dr., West Bloomfield, MI 48323

Action, Date Taken: Reprimand, Fine-\$1,000, Probation—2 yrs., 7-11-97

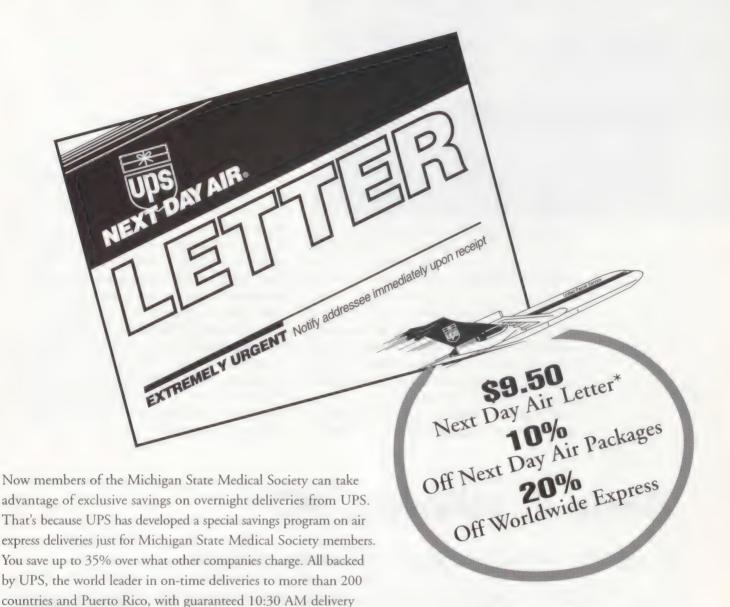
Reason: Failure to Meet Continuing Education Requirements

Name: Michael J. Septer, DO, PO Box 5038, North Muskegon, MI 49445

Action, Date Taken: License Suspended—6 mo. & 1 day, Fine—\$10,000, 8-17-97

Reason: Sister State Disciplinary Action

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Charles Zimont, MD

1997 MSMS Plessner awardee is home town broud

By Ralph D. Ward

Charles Zimont, MD, of Constantine, 1997 winner of the MSMS Plessner Award for outstanding rural practice, is a refreshing man to talk medicine with — if you can get him on the phone. When we rang his home for an evening interview, we received the message that he had been called out on an emergency. While this is not unusual for many practitioners, Doctor Zimont at least didn't have to travel far to see his patient — who was in the doctor's front yard. "People know how to reach me 24 hours a day" says Doctor Zimont. "They just drove up into our yard and asked if I'd look at their son, who had an arm fracture." All in a day's (and night's) work for a family practitioner who proudly calls himself "a bit of a dinosaur."

Doctor Zimont is a part of the community in Constantine, a small town just north of the Indiana border, with roots that go back a generation. "My father, Raymond D. Zimont, MD, was a physician here for years," and Charles grew up in the community, went to medical school at MSU, and served an internship at Bronson Hospital in Kalamazoo. However, medicine and the town of Constantine both drew him home. He returned, married his high-school sweetheart (they are still married 43 years later), and entered practice as a solo family rural physician, a job he has performed for four decades.

His workload as a general practitioner (he's one of the few who still deliver babies) is heavy. As a preceptor for medical students at the MSU Kalamazoo center, he finds that "in the training programs, they're used to three-in-one coverage; they don't know what it's like to be on duty 24-hours a day."

David R. Johnson, MD

Double Duty at the Department of Community Health

The duties faced by a chief medical executive for the Michigan Department of Community Health demand a lot, as David R. Johnson, MD, can attest. Recently, the job has become even more complex. Starting last May, Doctor Johnson, who has held the position since early 1996, gained the extra title of chief executive officer. This added day-to-day operational oversight to his current task of supervising medical aspects of the department's public health programs. "It adds to efficiency," observes Doctor Johnson. As to the increased work load, "We've always worked hard here, so I see no negatives. In fact, combining the functions has advan-

Doctor Johnson has solid credentials in the public health field, extending back to his work

with the Centers for Disease Control in Atlanta a decade ago. His history with the Michigan Department of Public Health (later the Department of Community Health) includes positions as epidemiologist, chief of the division of Disease Control, and chief of the Bureau of Infectious Disease Control. He is also an assistant clinical professor with the Department of Pediatrics and Human Development at MSU.

His early experience with communicable diseases "was my first background" in public health, Doctor Johnson notes, and is the north star by which he steers the department's agenda. "This shaped my interest in immunization issues, and very clearly immunization is a priority, particularly for kids. Over the last couple of years we've worked to raise immunization

But Doctor Zimont finds the rewards of his rural practice—being a crucial part of the community, more than outweigh the strains.

He still performs free physicals yearly for the local high school teams, and tries to be at every home game. "If there's an injury, they watch how fast I move onto the field. If I just walk out, they know it's probably not too serious. But when they see me run, they get worried."

At 65, Doctor Zimont scorns retirement, looking and feeling decades younger, and regularly relaxing on mountain backpacking trips with his family. He is deeply touched by his Plessner Award, bestowed by the MSMS board on those who "best exemplify the practice of a rural country practitioner."

But at his acceptance speech in May, Doctor Zimont accepted the award on behalf of



Doctor Zimont, left, MSMS Plessner award winner, attends to an injured high school wrestler and his coach at a meet.

other rural physicians as well, and donated his award money to his church. Such a move is typical of a man who sincerely believes the true rewards of a medical career are not monetary. "I tell young physicians to just get into rural health care, and the rewards will come—not just financial, but from the people."



levels in Michigan. We've risen from 42nd in the nation in 1991 to 36th today. Even the current level is not satisfactory, but it indicates we're headed in the right direction."

Doctor Johnson's other priorities for the department

equally forward-looking. "I want to bolster our basic disease surveillance system, so we better react to outbreaks of infectious disease. My personal priority is more intervention in the causes of chronic diseases, like cardiovascular disease, cancers and diabetes." Expansion of the department's community health assessment and improvement program, which funds local health initiatives, is also in the works.

Building strong relations with MSMS and other health care groups is a crucial part of Doctor Johnson's agenda. "If we use immunization as an example, public sector clinics do 40 to 50 percent of vaccinations. That means that 50 to 60 percent is done by the private sector. If we don't have an effective partnership [with physicians], we're lost."

The author is a Riverdale-based freelance writer.

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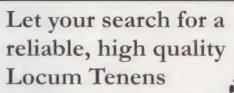
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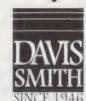
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Physician Accountability

New home health care law increases penalties

By Kathleen V. McKevitt

gnorance can be bliss. But not if you are certifying a patient for home health care coverage. Considered the future of long-term care for populations such as the elderly and the disabled, home health care currently is facing government scrutiny and attention-grabbing headlines in national media.

In August 1996, President Clinton signed into law the Health Insurance Portability and Accountability Act (HIPPA), which covers the portability of insurance and medical savings accounts. The act, which took effect immediately on August 21, 1996, also includes antifraud provisions that redefine how you, as a physician, will be held accountable for certifying patients as eligible for home health care benefits under Medicare.

Although Medicare guidelines for covered services have been in place since 19xx, they have not been published or circulated widely. Nonetheless, physicians are held accountable for following them. HIPPA, also known as the Kennedy-Kassebaum Act after its sponsors, Senators Edward Kennedy (D-Mass.) and Nancy Kassebaum (R-Kan.), imposes language and penalties on physicians who "knowingly" and with either "reckless disregard for" or "deliberate ignorance of" the truth certify that a patient meets all the Medicare requirements to receive home health care when the individual does not meet such requirements. The penalty for such false certification is not more than three times the amount of payment, or \$5,000, whichever is greater.

Joseph J. Weiss, MD, co-chair of the Michigan Medicare Carrier Advisory Committee, points out that "doctors should realize that they are not being picked on, but that the government views home health care as a large area of abuse. In the view of the government, the physician certifying a patient for home health care

is caring for the patient, even though the doctor may think that the responsibility is shared."

The requirements

Because of the severe penalties and the possibility that false claims of fraud will be brought against physicians, MSMS urges you to become thoroughly familiar with the Medi-

care guidelines for certifying that a patient is eligible for home health care. For a patient to be eligible to receive Medicare covered home health services, the physician must certify that the patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy, and/or speech therapy or continues to need occupational therapy.

The homebound condition

For a patient to receive home health services, you must certify that the patient is confined to his or her home or place of residence.

Patients do not have to be bedridden but, generally, must have a condition that restricts their ability to leave the home except with the aid of supportive devices. Or the assistance of another person or if leaving home is medically contraindicated. Absences from home must require great effort and be infrequent and of short duration.

A stroke patient who is confined to a wheelchair would meet the homebound condition. whereas an elderly person who can't leave because of feebleness would not unless he/she met some other condition. The Medicare regulations provide other examples that may help you with ambiguous situations.

Conditions of care

The patient you are certifying must be under your care and must need (1) skilled nursing care on an intermittent basis, (2) physical therapy or speech-language pathology services,

"We don't yet have experience with monitoring. The regulations are very complex and open to interpretation." Joseph J. Weiss, MD

Recommended Home Health Care Certification Statement

I certify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy, and/or speech therapy or continues to need occupational therapy. The patient is under my care and I have authorized the services on this plan of care and will periodically review the plan.

Physician name

lations specify in detail what the plan must contain and the conditions of signing it. Medicare will accept oral orders if specific rules are followed and a dated paper trail is established.

You must review and sign the plan of care at least every 62 days.

or (3) have a continuing need for occupational therapies. Medicare sets forth general principles governing these services, defines them using many examples, and details specific services about which questions are often asked.

Intermittent skilled nursing care

To be covered, the patient must intermittently (usually at least once every 60 days) require reasonable and necessary skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse. Determining whether a service requires such skills should be based on the complexity of the service, the condition of the patient and accepted standards of medical and nursing practice.

Physical therapy, speech-language pathology and occupational therapy

For the services of a physical therapist, speech-language pathologist or occupational therapist to be covered, they must be reasonable and necessary and of sufficient complexity that they can be performed safely and effectively only by or under the supervision of one of these skilled practitioners. The diagnosis or prognosis should never be the sole factor in deciding whether a service is skilled, but rather whether the skills of the therapist are needed to treat the illness or injury. The regulations provide examples and ambiguous situations.

Other services

The regulations define coverage eligibility for home health aides and medical social services.

Establishing a plan of care

As the treating physician, you, with the help of the home health care nurse, must establish a plan of care for the patient you are certifying. The regu-

Enforcement

Because 40 percent of all Michigan patients are on Medicare, you probably face these determinations frequently. Undoubtedly you have felt increasing pressure to get patients out of hospitals and into home health care. HIPPA's new provisions add to the heat. Furthermore, HIPPA provides funding to increase enforcement methods such as fraud reviews.

Doctor Weiss, who is preparing a review of the regulations and surveillance methods, says "we don't yet have experience with monitoring. The regulations are very complex and open to interpretation.

"We all have fears. Strong-arm interpretation could create problems for doctors. What will be important is whether those who are monitoring the regulations look at individual cases or look at patterns of care. A doctor intent on abusing home health care will probably establish a pattern of behavior. Monitoring this kind of abuse is a good thing."

Doctor Weiss will summarize the regulations and proposed surveillance methods at the October meeting of the Michigan Medicare Carrier Advisory Committee. MSMS will publish the resulting discussions.

To obtain a copy of the Medicare regulations for certifying a patient for home health care coverage, write or call Reimbursement Ombudsman Joyce Nuremberg at (517) 336-5722, or Patty Bokovoy at (517) 336-5723.

The author is a Laingsburg-based freelance writer.



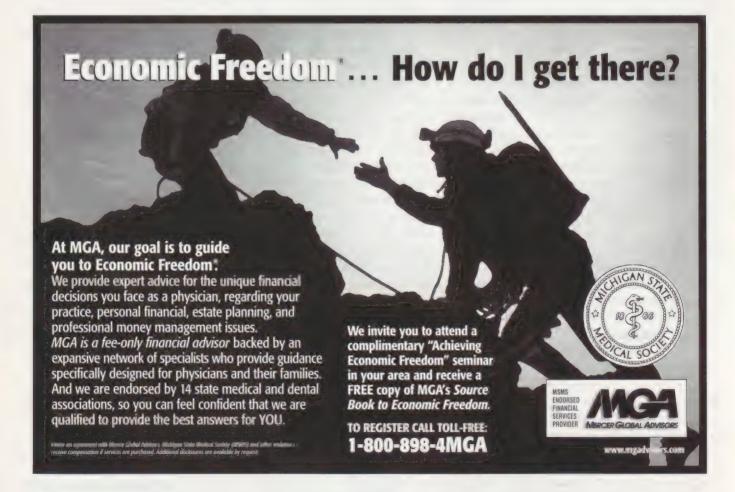
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MSMS Judicial Commission

"Listening Ear" for Aggrieved Patients

By Elizabeth A. Hutchinson, MD



The opportunity to be heard is often the critical issue for an aggrieved patient or patient's family when filing a complaint against a physician.

MSMS provides such a "listening ear," and seeks to determine the facts of the case, to examine the physician's perceptions and records as they relate to the complaint, and to render a fair determination regarding the complaint.

This listening ear is the Judicial Commission, composed of 10 elected district commissioners plus Richard D. Weber, MSMS Legal Counsel. The Commission meets quarterly to deal with complaints made against physicians who are members of MSMS. When an individual calls or writes with a complaint, MSMS staff sends that person a "Patient Request for Peer Review Proceeding" form. This form is to be completed, signed and returned within 30 days.

Subsequently, the complaint is forwarded to the county medical society in the county where the physician is a member, for investigation and for a determination to be made by their peer review committee (see "Suggested Procedures following Receipt of Notice"). The results can be appealed by either the complainant or the physician to the MSMS Judicial Commission. In rare cases, the Judicial Commission will assume original jurisdiction in a case. It should be noted that the Commission is not involved in matters of civil or criminal law, and no matter under active litigation is considered by the Commission.

Suggested procedures for county societies following notice of a complaint against a member physician

· Notify complainant that the complaint and a copy of the signed Patient Request for Peer Review Proceeding form has been received.

• Notify the physician(s) of the complaint lodged against them, provide them with a copy of the signed Patient Request for Peer Review Proceeding form and request a written response be submitted within 30 days.

• When the physician's response has been received, the matter should be reviewed by the peer review/ethics or peer review/mediation committee of your society. You may wish to request copies of records as part of the review. Note: for protection from liability, your society must have a bona fide peer review committee.

• The peer review committee should submit, within 60 days, a written determination regarding the disposition of the complaint to the complainant, the affected physician(s) and to the MSMS Judicial Commission. This communication should also indicate

that any final determination by the County Medical Society can be appealed by either party to the MSMS Judicial Commission.

Your Committee may wish to settle the problem by mediation.

It would be helpful if you would keep your Judicial Commission District Representative advised of the progress of the complaint as the above steps are taken, being careful to maintain strict confidentiality (e.g., avoid fax communication).

Additionally, at the July 16, 1997, meeting of the MSMS Judicial Commission, it was felt that the following two items should be shared with the county societies:

1) As a courtesy to the member physicians who will be the subject of a peer review, it would be appropriate to notify him or her by phone, in addition to the mailed notice. The physician can be assured that the purpose of the review is to provide a fair and impartial review of the complaint, and

that mediation of the dispute will be facilitated, if possible.

2) Please be aware that it is not the purpose of a peer review committee to determine if negligence or malpractice occurred. Rather, matters related to ethics, professional conduct, quality and appropriateness of care are to be considered. The complainant deserves acknowledgment of any portion of the complaint which the committee found valid, if such is the case, and deserves assurance that some corrective action will be taken. The physician deserves the friendly advice of peers, if a failing is found, in hopes of avoiding future problems. Rarely will more severe disciplinary action be reauired.

Feel free to contact your District Commissioner or Sherry Barnhart, MSMS Staff, at (517) 336-5786 or sbarnhart@msms.org/if you have any questions.

A physician who receives notice that a complaint has been filed against him or her is expected to respond to the county medical society, in writing, within 30 days. Failure to do so can result in disciplinary action. The peer review committee, in turn, is expected to arrive at a determination within 60 days (see the suggested procedures printed below).

In a three month period, MSMS typically receives anywhere from 25-50 complaints against physicians. It is interesting that 75 percent of the complaints received are against nonmember physicians. These complaints are referred to the Michigan Department of Consumer and Industry Services, Complaint and Allegation Division, with the State of Michigan.

The MSMS Judicial Commission dealt with 31 complaints in 1996. Fourteen of these originated before 1996. Twenty-eight of the 31 complaints have now been resolved, or the cases closed, due to the complainant's failure to sign an authorization to release medical records. The Commission currently has an additional four cases pending that originated in 1997.

The work of your District Commissioners, of the county society peer review committees and MSMS staff, provides the public with an opportunity to have a grievance reviewed and acted upon in a timely fashion. It is our hope that all parties involved will feel that they have been dealt with fairly when a resolution is achieved.

The author is chair, MSMS Judicial Commission

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Member Participation

What do members want from their organization?



By Michael G. Skinner, PhD

MSMS leaders and staff currently are involved in a strategic planning process. The author of this article is leading the planning sessions. Following are some of the insights he has shared as leaders and staff seek to plan a healthy, exciting future for your organization.

Why members don't participate

People join clubs, gyms and associations with every intention of getting involved and making a difference. Yet these good intentions are rarely turned into concrete, long-term action.

Organizations have spent billions of dollars to try and entice members into using services, often to no avail. Members have been studied, bullied, bribed, and offered rewards all in the cause of "getting them there." Nothing seems to work - at least not for very long.

Perhaps the answers are not in changing or rewarding those lazy, shiftless members who really "don't know what's good for them." Perhaps the answers are in changing the organization.

A recent study of 2,000 association members nationwide asked current members why they do and do not participate in services, educational offerings, and activities. The results are interesting because they say little about the members per se (except that they are human and tired of being taken for granted) and a lot about the lack of understanding and organization of their association.

The major reasons members do not participate in their association's activities are:

- 1. Events, programs, meetings and activities don't start on time.
- 2. Events, programs, meetings, and activities last too long.
- 3. Nothing gets accomplished at meetings.
- 4. They talk about the same old things, but never do anything about them.

- 5. The same people do everything.
- 6. The food is bad.
- 7. Meetings and events are poorly organized.
- 8. Not enough time is spent in business or networking.
- 9. The speakers are boring.
- 10. "It's just not much fun anymore."

 To understand the impact of these

reasons, it is important that paid staff and elected officers understand the problems facing their membership. In the same study members were asked to list the problems they face in their business or profession. The responses are:

- 1. lack of time
- 2. decreasing profitability
- 3. finding and keeping quality staff
- 4. government intervention and over regulation

Associations should exist to help their members solve their problems, develop their business or profession, and promote unity among the membership. Obviously, many associations have become a burden to their membership, doing little to help member become more successful in their business endeavors.

The ways to improve member participation are really very simple:

- 1. Stop doing the things that aggravate members and negatively affect participation.
- 2. Get organized and stay organized. Details like goals, agenda, and starting on time seem trivial, but they are not.
- 3. Truly value membership participation. People know when they are not wanted and if you ask members to participate you need to work with them, not around them.
- 4. Value member's time.
- 5. Train elected leadership in their duties, responsibilities, and how to run a meeting.
- 6. Serve good and interesting food. Buffets are best. Remember, people will not pay for airline quality food.

- 7. Remember that having no speaker is better than a bad speaker.
- 8. Help members solve their problems. To do this you must ask them regularly what their problems are.
- 9. Have some fun. Being successful is fun. Being around other positive, successful people is fun. Learning is fun.
- 10. Constantly renew and then reinvent the association by asking three simple questions: Where are we now? Where do we want to

go as an association? How do we want to get there?

Keep things simple. Keep things focused and, most of all, keep them member-friendly and your group will be successful.

Listen to your membership. They will tell you everything you need to know. But first you have to ask them!

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Editor's note: Do you have ideas you'd like to share regarding your MSMS, the strategic planning process and ways MSMS could better serve you? If so, please jot them down and send them to David K. Fox at MSMS headquarters, or e-mail them to Dave at dkfox@msms.org/

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Single Specialty Physician Networks

MSMS, AMA and specialties develop fourth case study

By William E. Madigan



MSMS, along with the AMA and six national specialty societies, is undertaking a case study of single specialty physician networks (SSPNs). As part of this case study, we participated in site visits to VIVRA Specialty Partners, an ENT network in Ft. Lauderdale, Florida, on May 7, and to the Atlantic Urological Associates, in Daytona Beach. Florida, on May 8. At these site visits, we learned the following lessons:

• SSPNs need strong, forward-thinking physician leaders who recognize that the overriding goal of a SSPN should be to help physicians succeed in a managed care environment, not to keep managed care out of their market.

• There may be a significant competitive advantage to being the first in a market to establish a SSPN. In fact, one of the physician leaders with whom we spoke stated that some physicians who had earlier refused to join his network now want to join, but are being excluded because the network does not need additional

 The timing of the establishment of a SSPN is often critical. Since a key purpose of a SSPN is to engage in managed care contracting, physicians should establish SSPNs only if area payers are interested in contracting through these networks. Thus, before establishing a SSPN, interested physicians should talk with area payers to avoid wasting considerable time and money in establishing a network with which third party payers are not interested in dealing.

• In forming a SSPN, it is preferable to start with a small group of high-quality physicians and expand from that core group if desirable. It is not usually a good idea to include all area specialists, because most third party payers are not interested in contracting with such a network.

• In order to be successful, SSPNs need to provide "value added" benefits to third-party payers. These benefits include quality management, utilization management and credentialing. Utilization management and quality management initiatives typically undertaken by SSPNs include:

disease management peer review focused on education rather than punishment clinical guidelines/protocols physician profiling

 The key to successful utilization management and quality manage-

ment is active physician involvement.

• In order to be successful, SSPNs need to be responsive to the market demand for measurable quality. In addition, physicians interested in forming a SSPN need to be sensitive to the fact that third party payers increasingly want to capitate specialists in order to fix their costs of delivering specialty care. The ENT network we visited began when several payers in south Florida suggested that physicians form a network in order to fix the cost of ENT care.

 Some SSPNs are undertaking patient and physician satisfaction surveys. Among the key patient satisfaction indices used by the two SSPNs we visited are:

Cleanliness of a physician's office.

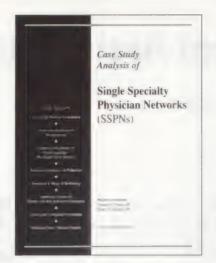
The amount of time spent in a physician's waiting room

The amount of time a physician spent with the patient

Outcome of the medical care provided Courtesy of the physician

Courtesy of the physician's staff

- SSPNs may be more successful in a market that is not dominated by large multispecialty group practices or large primary care-driven physician networks.
- The leaders of VIVRA stated that they view third party payers as their "customers" and are focused on satisfying them.
 - Some SSPNs that are paid capitation by



health plans reimburse their physicians on a discounted fee-for-service basis.

It may be preferable for SSPNs to begin capitation

contracting when fee-for-service payments are relatively high, because the capitation rate will be based on that higher-payment rate. If physicians wait until fee-for-service payments are discounted severely, the capitation rate will likely be smaller.

- Expert business and legal advisors are extremely important to the success of a SSPN.
- Physicians should get experience with capitation as soon as possible because they need to

learn how to deliver health care services on a budget.

• In order to engender strong physician commitment to a SSPN, physicians need to

invest a significant amount of money in a SSPN.

If you are interested in forming a SSPN, please contact Tom Wolff at Michigan Medical Advantage at (517) 351-0041 ext. 266. If you would like to order a copy of the SSPN case study, please call Patty Bokovoy at (517) 336-5723.

Mr. Madigan is executive director of MSMS.

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Case Study Analysis of Single Specialty Physician Networks (SSPNs)

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Certified Medical Assistants

Health care's versatile professionals

By Maxine R. Gordon, LPN, CMA

edical assistants (MAs) are widely viewed by physicians as vital members L of the health care delivery team. Perhaps your office employs a MA under a different title such as "receptionist," "biller," "transcriptionist," "administrative assistant" or "clinical assistant." Although these individuals have a variety of employment titles they can all be identified as "medical assistants."

The Michigan Society of Medical Assistants (MSMA), with the American Association of Medical Assistants (AAMA) is proud to celebrate "National Medical Assistants Week" October 20-24, 1997. This year's campaign is a nation-wide effort to educate the community on the importance of maintaining up-to-date childhood and adult immunization. MAs are in a position to prevent disease worldwide by explaining to patients the importance of keeping vaccinations up to date. Your role during this campaign is to recognize your employees as vital members of the medical profession and to encourage continuing education and certification through the professional organization.

The need for MAs

MAs are multiskilled health care professionals trained to assist physicians with administrative and/or clinical duties in an ambulatory or immediate care setting. MAs are proficient in a multitude of administrative and clinical tasks. These tasks include: EKGs; pulmonary function testing; venipuncture; xrays; assisting with examinations; patient history interviews and surgical procedures.

The MA also can do patient education, transcription, insurance billing, appointment scheduling, telephone and records management and instrument sterilization. The MAs educational background allows him or her to manage practice finances, write office policies and procedures, manage the physicians professional schedule and travel, market the practice, resource community services, the practice manage patient relations and other business related operations. As one can see, the MA performs a wide variety of tasks.

Certification

MAs demonstrate their knowledge and commitment to profession-

alism by achieving the Certified Medical Assistant (CMA) credential. Similar to other allied health professionals, in order to achieve this credential the MA must take a national examination. The comprehensive examination covers three areas of knowledge. These areas are administrative skills, clinical skills and general skills. General skills include law and ethics, human relations, medical terminology, anatomy and physiology, professionalism and communications. The CMA credential is achieved by MAs who have successfully completed the certification examination administered by the Certifying Board of the AAMA. The examination is offered twice yearly at test locations across the United States. The next certification examination is scheduled for January 30, 1998, with a registration deadline of October 1, 1997. Test sites within Michigan are Dearborn Heights, Flint, Kalamazoo, Traverse City, Troy and Waterford. Certification must be maintained every five years either through reexamination or by obtaining sixty (60) continuing education contact hours.

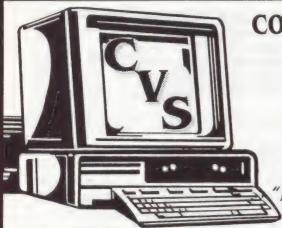
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Continuing education opportunities are designed to allow CMAs to stay current with developments and changes within the medical profession. Continuing education is obtained by attending various workshops, seminars, in-services and classes. The MSMA, an affiliate of the national level of AAMA, offers the opportunity to attend educational seminars and one state convention yearly. Affiliated component chapters within Michigan offer monthly education opportunities as well. The next educational seminar for Michigan assistants will be held September 26-28, 1997, in Traverse City, Michigan, at the Holiday Inn. For a program agenda and registration contact: (517) 337-1351. AAMA offers a national convention October 3-8, 1997, in Minneapolis, Minnesota. For an agenda and registration information call: (800) 228-2262.

Membership in the tri-level professional or-

ganization grants access to AAMA, MSMA, and 18 local chapters available throughout the state of Michigan. To obtain information you can visit the national web site at: http\\www.aama-ntl.org or call: (800) AAMA-ACT (800-228-2262). For information regarding a local chapter within your geographic area, membership and educational opportunities, contact MSMA: 1305 Abbot Road, P.O. Box 950; East Lansing, MI 48826-0950, (517) 337-1351, http\\www.msms.org or e-mail ckimmel@allstaff.msms.org.

The author is public relations chair for the Michigan Society of Medical Assistants.



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October

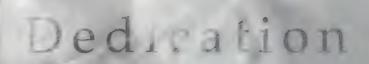
- 8, Primary Pain Management: Solutions for Your Chronic Pain Problems, Location: The Fairlane Club, Dearborn, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 8 Category 1 credits. Registration Fee: \$75
- 9, Long Term Care: Changing Times/Changing Directions. Location: The Management Education Center, Troy, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 6 Category 1 credits. Registration Fee: \$95
- 14, 21, Bar-Levay Educational Association Ongoing Seminar Series "What To Do When Religious and Other Beliefs are Used As a Pathologic Resistance." Contact: Lester Potempa, DO, Bar-Levay Educational Association, Location: 3000 Town Center, Suite 1275, Southfield, MI 48075, Phone (810)353-5333. No registration fee. Approved for: 4 Category 1 credits.
- 25, Nov. 4 Bar-Levav Educational Association Ongoing Seminar Series "Re-examining Fundamentals: The Apprenticeship Model in Training Psychotherapists." Contact: Lester Potempa, DO, Bar-Levav Educational Association, Location: 3000 Town Center, Suite 1275, Southfield, MI 48075, Phone (810) 353-5333. No registration fee. Approved for: 4 Category 1 credits.

- 26-30, 7th World Congress on Ultrasound in Obstetrics and Gvnecology. Location: Sheraton Washington Hotel, Washington D.C. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 31 Category 1 credits, 25 ACOG Cognates. Registration Fee: Pre-Congress \$175; Congress \$595
- 29, Care of the Terminally Ill Patient in the Primary Care Setting. Location: Towsley Center. University of Michigan, Ann Arbor, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, Phone (313) 736-1400. Approved for: 6 Category 1 credits.

November

- 5-7, MSMS Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. Contact: James Tarrant at MSMS (517) 336-7591. Approved for: up to 20 Category I credits.
- 12, Endocrinology Review Course. Location: The Fairlane Club, Dearborn, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 5.5 Category 1 credits. Registration Fee: \$80
- 12-14, Ultrasound in Obstetrics and Gynecology. Location: Towsley Center, University of Michigan, Ann Arbor, MI. Contact: Joyce

- Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, Phone (313) 736-1400. Approved for: 22 Category 1 credits.
- 13-15, Mayo Clinic OB/GYN Clinical Reviews. Location: Mayo Foundation, Rochester, MN. Contact: Registrars, Mayo Foundation, 200 First St. S.W., Rochester, MN 55905. Phone: (800) 323-2688. Fax: (507) 284-0532. Approved for: 16 Category 1 credits, 16 AAFP Prescribed Hours, 16 ACOG Cognates. Registration Fee: \$350.
- 22, Hepatitis C Video Conference. Location: 1.000 local satellite sites through the Public Health Training Network. Contact: Hepatitis Foundation International, 30 Sunrise Terrace, Cedar Grove, NJ 07009. Phone: (800) 232-3299. Approved for: 2.5 Category 1 credits, 2.5 AAFP Prescribed Hours. Registration Fee: \$25.
- 22, Update in Office Cardiology. Location: Novi Hilton, Novi, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, Phone (313) 736-1400. Approved for: 4 Category 1 credits.



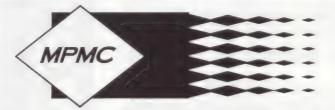
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Science and Art

On CME and Making a Difference

By Peter A. Duhamel, MD



As MSMS prepares for the Nov. 5-7 Annual Scientific Meeting in Dearborn, our focus turns to one of the elemental components that makes us physicians: our scientific knowledge of the workings and diseases of the human body. Our training uniquely qualifies us to care for patients, and our commitment to lifelong medical education is one of the cornerstones on which our profession and our medical society were founded.

The MSMS Annual Scientific Meeting is a tradition that has evolved through the years in order to deliver to members the most current and emerging information. Courses like "Pain Management and End of Life Care," and "Quality Improvement in Cardiovascular Care" reflect the relevance of the curriculum to the practice of medicine today.

I'm impressed that this year's program has taken relevance another step further: several special sessions have been developed especially for physicians and their office staffs, designed to keep both current on emerging issues, like "The Customer-Oriented Medical Practice." I believe these additions to the program are appropriate and timely steps for MSMS to be taking, and harbingers of more good things to come in terms of educational offerings, scientific and otherwise. The best part is, our patients will be the ultimate beneficiaries.

Physicians and families contribute

As our focus on the science of medicine is sharpened, we also look

this month at the art of what we do as physicians and as members of our communities. The special pull-out section celebrates and encourages the volunteer efforts we-and our spouses and families—take on in order to make a difference. Sometimes those efforts call upon our scientific training—as illustrated by the stories about free clinics or missions— to provide needed surgery in underdeveloped countries. But often the efforts involve giving our time, energy and imagination to others as a scout leader or community

MSMS members and their spouses and families do make a difference in such a variety of ways. I'm pleased that MSMS has collected these stories and shared them with all of us. Obviously they represent only a small percentage of the caring volunteer activities doctors and their families are involved in, but it is appropriate and timely to bring them into focus now. Their stories are harbingers of more good things to come.

Tailgate and donate

National "Make A Difference Day" will be recognized on Saturday, October 25. Both Blanche Mindlin, MSMS Alliance president, and I applaud our members' plans in place to open a new free clinic building in Flint, to collect needed supplies for a women's shelter in Kalamazoo and to conduct free screenings that day for patients in Oakland County, among other efforts across the state.

All physicians and their families can help to make a difference—one

way to do so is to contribute to the MSMS Foundation, which funds health and education projects throughout Michigan. Your September 25 Medigram included an envelope in which to make your tax-deductible contribution, as well as an invitation to a Make A Difference Day celebration. On October 25, MSMS and the MSMS Alliance will host a "Tailgate for Charity" event near Spartan Stadium in East Lansing just prior to the MSU-U of M football game. If you're planning to attend the game, please plan to join us at the tailgate—your \$25 dollar contribution per couple will, in part, support the MSMS Foundation, a charitable organization. (Contact Sheri Greenhoe at MSMS for details, at (517)336-7603 or at sgreenhoe@msms.org.)

As physicians skilled in the science of medicine, we have a contribution to make, and as members of our communities, we and our families have contributions to make, as well. I encourage and applaud your efforts, and the efforts of your colleagues recognized in this special issue. We thank them and their families for letting us tell their stories. knowing they represent many, many volunteer efforts quietly taking place every day.

Doctor Duhamel is 1997-98 MSMS president.



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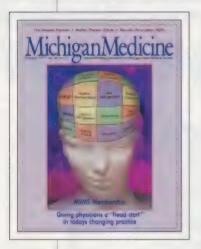
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COVER STORY



Membership: Giving physicians a "head start" in today's changing practice

24

As the health care environment continues to change, and as physicians position themselves to shape and manage and drive that change, membership in Michigan State Medical Society has never been more important.

MSMS, now more than 13,000 members strong, always has been on the fore-front of change, anticipating developments and providing solutions. MSMS physicians have been the ones to lead the discussion as the practice of medicine evolves. They face new challenges head on, confident that they have the clout and the tools to do so.

By Cathy O. Blight, MD and Louis R. Zako, MD

FEATURES

VIEWPOINT

The art of medicine: How to get the most out of hospice care 10

Despite a growing consensus in the medical community that hospice care is the treatment of choice for the terminally ill, the Michigan Hospice Organization contends that only one half of the patients who die from cancer in Michigan this year will receive hospice care.

By Tom M. George, MD

MEDICAL ETHICS

Making the hospice decision

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After much consideration and some discussion with family members and his primary doctor, a patient decided instead of more medical treatment for his terminal illness that he wanted to be treated locally and signed on with hospice.

By Donna Kondek

PHYSICIAN PROFILE

Michael H. Dawson, MD Injury helps physician understand patients' pain

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The trauma of a physician facing his own health crisis is presented in current books and movies as an experience both humbling and enlightening. However, Michael Dawson, MD, an orthopedist in solo practice in Adrian, knows this experience with far more personal immediacy and drama than any book or movie can share.

By Ralph D. Ward

November 1997 Volume 96, Number 11

MSMS Internet Website Address: http://www.msms.org/

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FEATURES

PHYSICIAN PROFILE

James L. McGauley, MD Getting it all together on patient information

In an age of exploding computer online and database technology, it would seem that medical practices must suffer from information overload. But what if the problem were in fact the opposite — too little comprehensive information on patients? James McGauley, MD, has set out to find a solution to this problem.

By: Ralph D. Ward

SPECIAL TRIBUTE

The Mother I knew: A personal tribute to Mother Theresa 40

MSMS member pays homage to Mother Theresa by sharing his personal experience with this extraordinary woman.

By Raj Bothra, MD

SPECIAL FEATURE

Truths and myths Narcotic medication usage for pain management

42

Jack Kevorkian's role in physician-assisted suicides has thrust the use of narcotic medication for patients suffering from non-cancer pain into the national spotlight. It follows that those medical doctors who do not believe in physician-assisted suicides need to provide their patients with an alternative form of effective bain control, which in some cases includes narcotic maintenance.

By Mark L. Gostine, MD

DEPARTMENTS

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Look for Michigan Medicine On-line at http://www.msms.org/

Question:

Would you encourage new physicians to join MSMS? Why?

Yes. In this age of specialization, it is important to be part of a medical society that includes the entire spectrum of physician thought and promotes collegi-

ality. We must all work together in the best interests of patient health, and MSMS membership provides a good opportunity to do this.

Cheryl Farmer, MD

Internal Medicine, Ypsilanti

Yes. New physicians must join! It is the single most democratic organization I know!

Kornelius Van Goor, MD

Dermatology, Grand Rapids

Yes. Support of the profession is a duty of every physician. This duty, at the level of state organization, can only be effectively provided by MSMS.

Michael J. Brennan, MD

Internal Medicine, Detroit

Yes. I would encourage every physician in Michigan to join MSMS because of the strength of participation and involvement. It is fulfilling and enlightening.

Kenneth Fisher, MD

Internal Medicine, Kalamazoo

Yes. MSMS provides an opportunity to interact directly with colleagues on a statewide basis regarding a number of issues important to the practice of

medicine in Michigan and nationwide. I would definitely encourage new physicians to join!

David E. Randolph, MD

Internal Medicine, Midland

Yes. MSMS is the only institution that protects the integrity of the profession.

Isak O. Berker, MD

Pulmonary Diseases, Lapeer

Yes. MSMS membership gives me credibility to address social issues, like child protection against harm by medical neglect, under any guise.

Francis A. Horvath, MD

Internal Medicine, East Lansing

Backtalk

BACKTALK is a nonscientific sampling of Michigan physicians' opinions on a topic of interest. Physicians are chosen at random and polled by telephone. We welcome suggestions for future topics. Send them to Michigan Medicine, Backtalk, P.O. Box 950, East Lansing, MI 48826-0950, or fax them to (517) 337-2490, or e-mail them to jmarr@msms.org/

Errata In the October issue of Michigan Medicine, incorrect information was printed in the article "Physician Accountability" on page 42. A partial date 19xx should have been removed entirely, and in the textbox on page 43, the word "recommended" should be absent from the statement title.

The editorial staff of Michigan Medicine apologize for these errors and have updated our records.

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Michigan Medicine, the official journal of the Michigan State Medical Society, is dedicated to providing useful information to Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of Michigan Medicine and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Board of Directors.

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the Voice of 13,000 Michigan Physicians

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WAYNE COUNTY

Wayne State School of Medicine receives national recognition

The Wayne State University School of Medicine is a national leader in providing physicians in key areas, according to the Association of American Medical Colleges



Robert J. Sokol, MD

(AAMC) 1996 Institutional Goals Ranking Report, issued in May. "WSU's leadership in these rankings reflects the School's commitment to meeting our mission to medical education," said WSU School of Medicine Dean Robert J. Sokol, MD. "We consider it our role not only to provide superior training and opportunity to our medical students, but also to provide physicians who will ultimately practice in key areas where they are most needed."

The AAMC rankings provide a comparison in order to assess an institution's achievement in certain areas. These areas are viewed as important goals for many medical schools and include the production of primary care physicians, the recruitment of underrepresented minorities into the medical profession, production of practicing physicians in the state and region and production of academic physicians.

With more than 1,000 medical students, WSU is among the nation's largest medical schools.

Detroit hospital receives recognition

Mercy Hospital of Detroit is being called the "comeback" hospital in the "comeback" city. The hospital is a recipient of the Seventh Annual (1997) Great Comebacks Award, a contest co-sponsored by Hospitals & Health Networks, a publication of the American Hospital Association, and Coopers &

The national award is given to hospitals in two bed-size categories that have made innovative changes in management, financial initiatives and physician relations to yield financial changes and turnaround from financial distress to stability. Mercy Hospital won the award for the 150-or-more beds category.

"A critical component of Mercy's 'comeback' is the development of community relationships, partnerships and collaborations that enhance our image as a valuable asset in the community," says Brenita Crawford, president and chief execu-



Mercy Hospital Board of Directors

Share your news with us "Across the State" is an excellent vehicle for communicating the activities of your county medical society or specialty society. Send your information to: Tom Seely, MSMS chief of physician outreach programs, P.O. Box 950, East Lansing, MI 48826-0950. Phone: (517) 336-5770. Fax: (517) 337-2490. E-mail tseely@msms.org.

tive officer. "By focusing on the health care needs of the community, Mercy has aggressively developed programs in the core services of senior medical/surgical care, behavioral health and renal dialysis. Emphasis on these services respond directly to some of the leading health care problems in our community such as cardiovascular disease, hypertension, diabetes and chronic mental illness."

GENESEE COUNTY

Bernard A. Harris, MD, FACP, Astronaut, addresses medical society and their families

The Genesee County Medical Society hosted an evening with Astronaut Bernard A. Harris, MD, on September 4 and 5, 1997. Doctor Harris not only is a physician with 26 articles published in medical journals, but has also flown two space shuttle missions. He has walked in space and is now a vice president of Spacehab, Inc.

Doctor Harris spoke to the Genesee County Medical Society's General Membership meeting—to a crowd numbering over 200—and to children from the Urban League of Flint, Pierce-Cultural Center School, the Police Athletic League and Springview Elementary on September 4.

This was the perfect setting for his inspirational message regarding the need for children to follow their dreams. Doctor Harris described how he was able to accomplish his goals of becoming both a physician



Bernard A. Harris, MD, FACP

and an astronaut. He had wanted to be Superman—and by going to space he was able to fly like Superman, despite starting out as an African American child living on a Navajo Indian Reservation.

On September 5, he was the feature speaker at the Flint Rotary. His message at this meeting dealt with

the need for businesses to innovate and think globally, and for people to follow their dreams.

Doctor Harris' visit was sponsored by support from Genesys Regional Medical Center, Hurley Medical Center and McLaren Regional Medical Center.

Managed Care Tort Liability

By Richard D. Weber, JD

MSMS Legal Counsel



Question: HMOs and other managed care organizations have become dominant in the delivery of medical care. It is no secret that these HMOs are primarily focused on cost savings, oftentimes at the expense of quality. In pursuing cost saving objectives, these organizations effectively control the quality of health care delivery, and yet the liability for sub-par health care treatment is imposed upon the treating physician. Does an HMO have any potential liability for effectively controlling the quality of health care?

Answer: HMOs and other managed care organizations (MCOs) have generally escaped state tort liability by successfully asserting that the federal Employee Retirement Income Security Act (ERISA) preempts such tort actions. Plaintiffs who have asserted negligence claims against MCOs routinely have had their cases removed to federal court. where judicial relief is limited by the ERISA preemption clause. This federal legislation voids state laws that "relate to" employee benefit plans. Under ERISA, beneficiaries may recover benefits due under the terms of the plan, but such relief is meager when compared to the remedies available under state tort law, which includes compensatory damages and damages for pain and suffering. This has left doctors as the "deep pocket" defendants, subject to state tort claims, even when the doctor's judgment is superseded by MCOs' cost containment decisions.

Recently, the courts have narrowed the application of the ERISA preemption clause in cases where the plaintiff alleges that an MCO was negligent in providing medical care under an employee benefit plan. Although there is lack of unanimity, recent federal appeals court decisions have upheld state law claims against MCOs that asserted vicarious liability for the malpractice of the MCO's providers or negligent provision of treatment. However, the courts continue to deny claims based strictly on a benefits determination under a plan on the basis that the payment of benefits is preempted by ERISA and any change will require congressional action. These courts distinguish an allegation of negligent delivery of medical treatment from an allegation based solely on a utilization review determination or a "medical benefits" decision.

Texas has recently enacted legislation that establishes the liability of MCOs that engage in negligent health care decision-making resulting in patient injury. Not surprisingly, the Texas law is being judicially challenged by the managed care industry as preempted by ERISA. This case is being followed closely by MSMS legal counsel.

The Texas legislation creates specific statutory bases for patients to assert claims against MCOs for failure to exercise ordinary care when making health care treatment decisions or for failure of MCO employees, agents or representatives to exercise ordinary care. Ordinary care of an MCO is that degree of care that an MCO would use under the same or similar circumstances. In the case of an agent of the MSO, ordinary care is that degree of care that a person or ordinary prudence in the same profession, specialty, or area of practice as such person would use in the same or similar circumstances. Significantly, the Texas statute also precludes an MCO from including an indemnification or hold harmless clause in a contract with a participating health professional. This eliminates the right of an MCO to shift its liability back to the physi-

Legislation similar to the Texas statute was introduced in Michigan prior to the time this column was published.

The Michigan bill—House bill 5221, introduced by Representative Laura Baird-will track the Texas statute closely. It is expected to have substantial opposition from the insurance/managed care lobby. If enacted, it is expected to be challenged under the ERISA preemption clause, unless the issue has then been determined by the United States Supreme Court or the Sixth Circuit, which establishes binding precedent in Michigan.

Two federal proposals seek to establish expanded liability for MCOs where treatment decisions injure participants. A bill sponsored by

continued on page 52

What's Your Question? MSMS legal counsel will answer if you send your query to Judith Marr, Editor P.O. Box 950, East Lansing, MI 48826-0950, or e-mail her at jmarr@msms.org.

In hypertension

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Substantially lower cost than Procardia XL and Norvasc^{‡5}

Once-A-Day



30mg,60mg &90mg

A PRACTICAL CHOICE

Adalat CC is not indicated for angina. It should be taken on an empty stomach. As with all distinct pharmacologic entities, switching from one to another may necessitate careful titration and patient monitoring.

*Procardia XL (nifedipine) and Norvasc (amlodipine besylate) are registered trademarks of Pfizer Labs Division, Pfizer Inc.

†Frequency and type of side effects are typical of dihydropyridine calcium channel blockers.⁶

‡Calculations based on suggested Average Wholesale Price (AWP).⁵ AWP is from a published price list and may or may not represent the actual price to pharmacists or consumers.

Please see brief summary of Prescribing Information on following page.



30mg, 60mg & 90mg

A PRACTICAL CHOICE

BRIEF SUMMARY CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION For Oral Use

P7500046BS

INDICATION AND USAGE: ADALAT CC is indicated for the treatment of hyperten-CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

CONTRAINDICATIONS: Known hypersensitivity to nifedipine.

WARNINGS: Excessive Hypotension: Although in most patients the hypotensive effect of nifedipine is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients using concomitant beta-blockers.

Severe hypotension and/or increased fluid volume requirements have been reported in patients who received immediate release tapsules together with a beta-blocking agent and who underwent coronary artery byposs surgery using high dose lentanyl anesthesia. The interaction with high dose fentanyl appears to be due to the combination of infedipine and a beta-blocker, but the possibility that it may occur with infedipine alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesis connot be ruled out. In infedipine-treated patients where surgery using high dose tentanyl entanglements is contemplated, the physician should be aware of these potential problems and, if the patient's condition permits, sufficient time (at least 36 hours) should be allowed for nifedipine to be washed out of the body prior to surgery.

snound be dillowed for intelligible to be wished out of the body prior to surgery.

Increased Angine and/or Myocardial Infarction: Rarely, patients, particularly those who have severe obstructive coronary artery disease, have developed well documented increased frequency, duration and/or severity of angine or acute myocardial infarction upon starting nifedipine or at the time of dosage increase. The mechanism of this effect is not established.

Beter-Blocker Withdrawal: When discontinuing a beta-blocker it is important to taper its dose, if possible, rather than stopping abruptly before beginning nifedipine. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholomines. Initiation of infedipine ent will not prevent this occurrence and on occasion has been reported to incre

Congestive Heart Failure: Rarely, potents (usually while receiving a beta-blocker) have developed heart failure after beginning affections, or Street with tight cortic stensist may be at greater risk for such an event, as the unloading effect of infedipine would be expected to be of less benefit to these patients, owing to their fixed impedance to

flow across the aortic valve.

PRECAUTIONS: General - Hypotension: Because nifedipine decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and
titration of ADALAT CC is suggested. Ose observation is especially recommended for patients
already taking medications that are known to lower blood pressure (See WARNINGS).

Peripheral Edema: Mild to moderate peripheral edema occurs in a dose-dependent
manner with ADALAT CC. The placebo subtracted rate is approximately 8% at 30 mg,
12% at 60 mg and 19% at 90 mg daily. This edema is a localized phenomenon, thought
to be associated with vasodilation of dependent arterioles and small blood vessels and
and due to left ventricular dysfunction or generalized fluid retention. With patients whose
hypertension is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Advancation Res. Pestanese: ADALAT CC is aventeded releases tabled and should be

entiate this peripheral edema from the effects of increasing left ventricular dysfunction.

**Information for Patients: ADALAT CC is an extended release table! and should be swallowed whole and taken an an empty stamach. It should not be administered with food. Do not chew, divide or crush tablets.

**Laboratory Tests: Rare, usually transient, but accasionally significant elevations of enzymes such as licklaine phosphases, CPK, LDH, ScOT, and SOPT have been noted. The relationship to nifedipine therapy is uncertain in most cases, but probable in some. These laboratory abnormalities have rarely been associated with clinical symptoms, however, cholestasis with or without joundice has been reported. A small increase (<5%) in mean alkaline phosphatase was noted in patients treated with ADALAT CC. This was an isolated finding and it reapt resulted in values which fell outside the normal range. Rare instances of allergic hepatitis have been reported with nifedipine treatment. In controlled studies, ADALAT CC did not adversely affect serum unit and, glucose, cholesterol or potessium.

Nifedipine, like other calcium channel blockers, decreases platelet aggregation in vitro.

ADALAI CC did not odversely affect serum unic acid, glucose, cholesteral or potassium. Mifedipine, like other calcium channel blockers, decreases platelet aggregation in vitro. Limited clinical studies have demonstrated a moderate but statistically significant decrease in platelet aggregation and increase in bleeding time in some nitedipine patients. This is thought to be a function of inhibition of calcium transport across; the platelet membrane. No clinical significance for these findings have been demonstrated. Positive direct Coombs' test with or without hemolytic anemia has been reported but a causal relationship between nifedipine administration and positivity of this laboratory test, including hemolysis, could not be determined.

Although infeligline has been used safely in patients with renal dysfunction and has been reported to exert a beneficial effect in certain cases, rare reversible elevations in BUN and serum creatinish have been reported in patients with pre-existing fromic renal insufficiency. The relationship to nifedipine therapy is uncertain in most cases but probable in some. Drug Interactions: Beta-adrenergic blocking agents: (See WARNINGS).

ADALAT CC was well tolerated when administered in combination with a beta blocker in 187 hypertensive patients in a placebo-controlled clinical trial. However, there have been occasional literature reports suggesting that the combination of nitedipine and beta-adrenergic blocking drugs may increase the likelihood of congestive heart failure, severe hypolension, or exacerbation of angina in patients with cardiovascular dislaves, severe hypolension, or exacerbation of angina in patients with elevated diagoxin levels, and there is a possible interaction between digoxin and ADALAT CC, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing ADALAT CC to avoid possible over- or under-digitalization.

Courant Anticogulants: There have been rare reports of increased prothrombin time in patients taking coumarin anticogulants to whom nifedipine was administered. However, the relationship to nifedipine therapy is uncertain.

the relationship to nitedipine therapy is uncertain.

Quinidine: There have been rare reports of an interaction between quinidine and nifedipine (with a decreased plasma level of quinidine).

Cimetidine: Both the peak plasma level of nifedipine and the AUC may increase in the presence of cimetidine. Ranifoldine produces smaller non-significant increases. This effect of cinymetidine may be mediated by its known inhibition of hepatic cytothorne P450, the entryme system probably responsible for the first-pass metabolism of nifedipine. If nifedipine therapy is initiated in a patient currently receiving cimetidine, curvious thirdners of wised.

py is initiated in a patient currently receiving cimelitine, contious throtton is advised. Carcinagenesis, Mutagenesis, Impairment of Fertility. Nifedipine was administered arally to rats for two years and was not shown to be carcinagenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo mutagenicity studies were negative. Pregnancy: Pregnancy Category C. In rodents, rabbits and monkeys, nifedipine has been shown to have a variety of embryotoxic, placentotoxic and letatoxic effects, including stunted fetuses (rots, mice and rabbits), digital anomalies (rats and rabbits), rib deformities (mice), cleft polate (mice), small placentos and underdeveloped chorion: villi (mankeys), embryonic and fetal deaths (rats, mice and rabbits), prolonged pregnancy (rats; not evaluated in other species), and decreased neonatal survival (rats; not evaluated in other species), on and my complete the doses associated with these various effects are higher than the maximum recommended human dose and some are lower, but all are within an order of magnitude of it. The digital anomalies seen in infediginine-exposed rabbit pugs are strikingly similar to

The digital anomalies seen in nifedipine-exposed rabbit pups are strikingly similar to those seen in pups exposed to phenytoin, and these are in turn similar to the phalangeal deformities that are the most common malformation seen in human children with in utero exposure to phenytoin.

There are no adequate and well-controlled studies in pregnant women. ADALAT CC should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus. Nursing Mothers: Nifedipine is excreted in human milk. Therefore, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the

ADVERSE EXPERIENCES: The incidence of adverse events during treatment ADALAT Ct in dose up 19 0 mg aduly were derived from multi-tenter placebo-controlled clinical trials in 370 hypertensive potients. Atenolol 50 mg once daily was used concomi-tantly in 187 of the 370 patients on ADALAT CC and in 64 of the 126 patients on placebo-ful adverse events reported during ADALAT CC therapy were tabulated independently of their causal relationship to medication.

their causal relationship to medication.

The most common adverse event reported with ADALAT® (C was peripheral edema. This was dose related and the frequency was 18% on ADALAT (C 30 mg daily, 22% on ADALAT (C 60 mg daily and 29% on ADALAT (C 90 mg daily versus 10% on placebo.

Other common adverse events reported in the obove placebo-controlled trials include: Headache (19%, versus 13% placebo incidence); Flushing/heat sensation (4%, versus 0% placebo incidence); Eushing/heat sensation (4%, versus 0% placebo incidence); Plashing/heat sensation (4%, versus 0% placebo incidence); Genstjopion (1%, versus 0% placebo incidence); Genstjopion (1%, versus 0% placebo incidence).

Where the frequency of adverse events with ADALAT CC and placebo is similar, causal relationship cannot be established.

The following adverse events were reported with an incidence of 3% or less in daily doses up to 90~mg:

Body as a Whole/Systemic: chest pain, leg pain Central Nervaus System: paresthesia, verligo Dermatologic: rash Gastrointestinal: constipation Musculoskeletal: leg cramps Respiratory: epistaxis, rhinitis Urogenital: impotence, urinary frequency

Other adverse events reported with an incidence of less than 1.0% were

Other adverse events reported with an incidence of less than 1.0% were:

Body as a Whole/Systemic: callulisis, chills, facial edema, neck pain, pelvic pain, particular distribution, brodycardia, cardiac arrest, extrasystole, hypotension, polpitations, phlebitis, postural hypotension, nachycardia, cutaneous angiectases Central Nerveus System: anxiety, confusion, decreased hibido, depression, hypertonia, insomnia, somnolence Dermatologic: pruritus, sewesting Gastrointestinal: abdominal pain, diarrhea, dry mouth, dyspepsia, esophaglis, flatence, gastrointestinal hemorrhage, vomiting. Hematologic: lymphadenopathy Metabolic: gout, weight loss Musculoskeletal: carbralgia, arthritis, myalgia Respiratory: dyspnea, increased cough, rales, pharyngitis Special Seuses: abnormal vision, amblyopia, conjunctivitis, diplopia, tinnitus Uragenital/Reproductive: kidney calculus, nocturia, breast engargement

The following adverse events have been reported rarely in patients given nifedipine in Interfollowing adverse events have been reported rarely in patients given intedigine in other formulations: allergenic hepatitis, alopecing, anemia, arthritis with AMA (+) depression, erythromelolgia, exfoliative dermatitis, fever, gingival hyperplasia, gynecomastia, leukopenia, mood changes, muscle cramps, nervousness, paranoid syndrome, purpura, shakimess, sleep disturbances, syncope, laste perversion, thrombocytopenia, transient blindness at the peak plasma level, tremor and urticaria.

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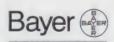
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The art of medicine

How to get the most out of hospice care



By Tom M. George, MD

espite a growing consensus in the medical community that hospice care is the treatment of choice for the terminally ill, the Michigan Hospice Organization contends that only one-half of the patients who die from cancer in Michigan this year will receive hospice care. This is not due to a lack of insurance coverage or a shortage of hospices.

Michigan has 114 hospice programs that together cover the entire state, and most will accept Medicare, Medicaid and uninsured patients. Nearly all commercial health insurance policies provide a hospice benefit, so there should almost never be a lack of access to hospice services in Michigan.

Not only is the low admission rate a problem, but hospice stays are too short. Medicare and Medicaid patients become eligible for hospice services when they have a prognosis of six months or less to live. Nationally however, the average hospice stay of a Medicare patient is only 36 days. Almost one-third of hospice patients are in a program for only two weeks or less. Sixteen percent die within seven days of enrollment. (Survival of Medicare Patients After Enrollment in Hospice Programs, Nicholas A. Christakis, MD, PhD, MPH, and Jose J. Escarce, MD, New England Journal of Medicine, July 18, 1996 pp 172-78.) In 1996, Michigan's median hospice stay of only 25 days was 30 percent lower than the national average according to Michigan Hospice Organization. Our local hospice sends out monthly family satisfaction surveys and one of the most frequent comments is, "We wish we would have gotten into hospice sooner."

Criteria for hospice care

What needs to be done to improve hospice utilization and care for the terminally ill in Michigan?

First, physicians need to be familiar with the

criteria Medicare uses for determining hospice eligibility. Second, we need to be comfortable initiating a discussion about the option and timing of hospice care with our terminally ill patients. Third, once a patient is admitted to a hospice program the admitting physician can and should continue to actively manage their

Physicians should know the three requirements that must be met for Medicare to cover a hospice stay:

- the patient must have a terminal illness (not necessarily cancer)
- the patient must be willing to forego curative treatment
- the admitting physician must certify that the patient has a life expectancy of less than six months.

If a physician is unsure whether a patient meets these criteria, the hospice can usually help in making a determination. The National Hospice Organization has even published sets of worksheets that can be used to estimate the prognosis for several cancer and non-cancer diagnoses. For non-cancer patients, such things as unintended weight loss, declining functional capabilities and laboratory or radiological evidence of disease progression may help qualify the patient for the Medicare hospice benefit.

In choosing hospice, the Medicare patient waives coverage for curative treatment of the terminal illness. In return, they obtain new services that are not otherwise covered. The hospice benefit includes home nursing visits, home health aid services, chaplain services, prescription coverage and bereavement counseling for family members.

How hospice works

The hospice benefit provides for palliative care and symptom management and continued

treatment of any concurrent illnesses. The majority of hospice patients receive care at home. These patients need to have a caregiver, friend or family member who can be home with them because the Medicare hospice benefit does not provide for around-the-clock nursing care at home. For those patients who do not have help in their home, hospice care can usually be delivered to a nursing home, adult foster care center or assisted living center, and there are a growing number of residential hospice settings that provide an alternative site for patients when home care is inappropriate.

Physicians can improve end-of-life care by tactfully presenting hospice as one of the treatment options available to their newly diagnosed terminally ill patients. Michigan's new Death with Dignity Act actually mandates that physicians give terminally ill patients information about pain control and hospice care. By introducing the idea of hospice care early in the course of a terminal illness, patients have the chance to benefit from longer hospice stays. Physicians should not wait until the patient is near death to recommend hospice care.

When talking to their terminally ill patients about hospice, physicians should be prepared to dispel some common misconceptions. Patients may think that admission to hospice means they are going to be sent someplacethey may not know that hospice care is typically delivered in their home. They may also feel that hospice care means "no care"—they often don't understand that hospice care is highly technical and labor intensive.

The terminally ill patient needs to be reassured that bringing up hospice care does not indicate that the doctor is "giving up on them," only that a shift in priorities to symptom management may now be in order. Patients should be told that hospice care is sometimes only temporary; if their prognosis improves, they may be discharged. Finally, patients are usually pleased to learn that they can keep their own

doctor while in hospice, and that their doctor will continue to actively manage their care.

Good hospice care requires the involvement of the admitting physician. Once a patient enters a hospice program, the admitting physician will be asked to provide medication orders. There are usually optional standing orders for symptom management and it is vitally important that contingencies be made for pain control. Most cancer pain can be controlled with escalating doses of oral analgesics and hospices will usually have protocols for this that can be approved or modified by the admitting physician. If needed, hospices should be able to manage intravenous or subcutaneous infusions, including patient-controlled analgesia, or other advanced pain-control techniques.

A group effort

Medicare requires hospices to provide a multidisciplinary care team that usually consists of the hospice medical director, nurses, home health aides, pharmacists, social workers, volunteers and chaplains. Members of the hospice team specialize in treating the terminally ill and should be able to provide recommendations regarding symptom management and pain control to the admitting physician; however, the admitting physician typically knows the patient better than the hospice personnel and should individualize the patients' treatment as needed.

The admitting physician should receive frequent updates on the patient's condition from the hospice staff and is invited to participate in periodic meetings with other members of the hospice team where the patient is discussed another Medicare requirement.

Patients who are not homebound should continue to keep physician office appointments.

Homebound patients may sometimes need a house call by the admitting physician. If the admitting physician is unable to make a needed home visit, the hospice medical director may be able to do this instead. As the patient's dis-

"Our local hospice sends out monthly family satisfaction surveys and one of the most frequent comments is, 'We wish we would have gotten into hospice sooner."

"The time spent by the admitting physician providing medical management of hospice patients is reimbursable under Medicare rules for care plan oversight services."

ease progresses, there will likely be a need for increasing pain and symptom control measures. The time spent by the admitting physician providing medical management of hospice patients. including time on the telephone and any time attending team meetings, is reimbursable under Medicare rules for "care plan oversight services" (CPT code 99475). Other physician services continue to be reimbursed as usual under Medicare Part B.

Terminally ill patients are not taking full advantage of Michigan's hospice programs. Endof-life care in Michigan can be improved by physicians familiarizing themselves with hospice eligibility requirements, making earlier referrals to hospices, and remaining actively involved in their patients' hospice care.

The author is co-chair of the MSMS Committee of Hospice Medical Directors.

Making 'cents' of Hospice Billing

One concern involved with the admission of patients into hospice is the question of reimbursement of the primary physician. The myth surrounding this issue is that physicians will lose income. This is not true. Although hospice's home-care focus and interdisciplinary team involvement can potentially reduce the number of physician office visits and hospital stays, attending physicians can bill Medicare and other carriers for regular visits related to the hospice care plan.

- The attending physician continues to bill Medicare Part B for professional services—home, inpatient or nursing home visits—in the usual manner, independent of the hospice benefit.
- Medications, laboratory tests and other non-physician services required for the management of the terminal illness are paid for by the hospice program through the hospice benefit.
- Attending physicians can bill for care plan oversight for hospice patients.
- Payment under CPT code G0065 encompasses significantly complex medical management requiring the integration of new information into the plan of care or adjustments in medical therapy furnished by the physician.

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Making the hospice decision

By Donna Kondek

hen Wally Potter, 57, was hospitalized in May of this year for severe congestive heart failure with complications, he acknowledged to his physician, "It's getting harder to take this fluid off me than before." His hospital stay included six days in the intensive care unit for the former smoker, whose heart problem is compounded by emphysema, diabetes, hypertension, peripheral vascular disease and renal failure. His history also includes heart attacks, a stroke and ulcers.

His physician, Craig K. Matheson, DO, tuned into the thoughts and feelings behind Mr. Potter's spoken observation. A family practitioner with the Pine Medical Group in Fremont, he had taken Mr. Potter on as a patient during a hospitalization in October 1996.

"Wally's heart is wearing out," explains Doctor Matheson, who is also medical director of the Hospice of Newaygo County. "We discussed all the possibilities open to him," says the physician, who explained honestly to Mr. Potter that he was not an organ-transplant candidate.

Doctor Matheson presented to Mr. Potter a range of options that included traveling out of town several times a week for dialysis; continuing as before, with more frequent and longer hospitalizations; doing nothing or entering a hospice program. Doctor Matheson made it clear he did not expect Mr. Potter to make a decision right then and would respect whatever decision he did make. ("I'll bluntly tell patients 'I'm not Doctor Kevorkian," he stresses. "'I'm not here to promote your death or quicken it.")

"We had some good talks in the hospital at that time," Doctor Matheson notes. "I tell all my patients that I want them to make informed decisions. I impressed on him that I wanted him to be making the decisions; neither I nor his family were making the decisions for him."

A patient's choice

Wally Potter left the hospital May 22, initially leaning toward the dialysis option. After much consideration and some discussion with family members, he decided instead he wanted to be treated locally and signed on with hospice. "I've always been very independent. I wanted to have the best quality of life I could have," says Mr. Potter, a Vietnam veteran and former truck driver who lives with his elderly mother in a house in Fremont, where he

grew up. "But it [making the decision] is always a hard choice," he concedes.

"I think doctors ought to be completely honest," Mr. Potter adds. "As things develop, keep patients informed of it, so that they can help make the decisions. If you know what's going on and it's explained to you in plain English, where you can understand it, then you can comprehend it and process it, and help yourself make a decision."

"Basically, you know you're going to die. I think with hospice it makes you more stable, more able to make your own decisions, to live your life the way that you want to, not the way somebody else would want you to live. It [being terminally illl scared me. But it also gave me the chance to make my decisions on how I wanted to live."

Mr. Potter's relatives, consulting physicians and hospice personnel are all as involved in his care as possible, Doctor Matheson notes. "But Wally is in the driver's seat. We're all in the vehicle, but he's got the brakes, the gas and the shifter. We may all be navigators, but he decides where we finally go."

"With the treatment I'm getting now, the way I'm being taken care of, it would make no sense for me to go back in the hospital," Mr. Potter adds. "There wouldn't be any more



Marie Malone, RN, BSN, Director of hospice of Newaygo; Craig K. Matheson, DO, medical Director of Newago County; and Susan Mast, RN, OCN, Mr. Potter's nurse.

they could do for me there than is being done now."

Hospice nurses and aides work with him at home almost daily. His brother Gary, who came to the ICU every day, drives him to church or the local restaurant when he feels well enough to go out, and a sister helps out, buying groceries. One recent morning, an aide scheduled to visit Mr. Potter found that he was playing hooky. Gary had taken him out for coffee, making the most of one of Mr. Potter's better days. The aide later learned why he hadn't been home and gladly rescheduled their appointment for another time.

Primary physician involvement

Doctor Matheson has been involved with the hospice since early 1992. Although he learned what hospice was in medical school, he did not immerse himself in the hospice philosophy until he became medical director, when reading, attending seminars and "just doing" constituted his real education. "Certainly, I like the philosophy of keeping the patient in control, independent

dent and staying at home," he notes.

During his medical training, Doctor Matheson had a rotation with a pulmonary specialist and underwent what he calls "an important learning experience." The specialist was treating a man dying of lung cancer and was scheduled to meet with the patient's family and break the news to them in a family conference. "I watched this guy struggle with this issue; he knew all day that he'd have to meet with the family and he was not looking forward to it. He looked at me and said, 'I can't imagine that you'd ever want to do this,'" says Doctor Matheson. "Then he was mad that the family was asking questions and the dying man was making unusual requests.

"As a resident, making rounds with someone else, you observe; you watch the interaction and the dynamics. I thought, but did not tell him, 'I'd *love* to talk to the patient and family. I think it would be great.' And I thought, 'The man is dying; give him what he wants."

Many physicians are uncomfortable talking to patients about dying, Doctor Matheson ad-

"I think doctors ought to be completely honest," Mr. Potter adds. "As things develop, keep patients informed of it, so that they can help make the decisions. If you know what's going on and it's explained to you in plain English, where you can understand it, then you can comprehend it and process it, and help vourself make a decision."

"I do read the obits," Ms. Malone says, "and I know there are people dying at home. And my concern is: Why didn't we have them?" mits. And some patients wait for their physician to bring up the subject.

"We're taught in medical school that life is success and death is failure," he observes, explaining that reality is never so clearly black and white. Every morning when Doctor Matheson went back to work during Mr. Potter's May hospitalization, he would not have been surprised to learn that Mr. Potter had died the night be-

With some illnesses, especially non-cancer diagnoses, accurately predicting a patient's remaining life span is difficult. Doctor Matheson knows of patients who died during the initial hospice interview, while others have stabilized, left the program and survived for several years.

Hospice underutilized in Michigan

Hospice of Michigan statistics to date for 1997 show the average hospice stay is only 42.2 days, well under the six-month life-expectancy limit, says Marie Malone, RN, BSN, program director for the Hospice of Newaygo County. Because hospice care involves psychological, emotional and spiritual issues and family dynamics, as well as physical needs, the sooner a patient enters the program, the more the hospice team can help, Ms. Malone stresses the family needs time to build a trusting relationship with the team and prepare for the death.

"Some people have the impression that hospice means death, and that's too bad because we don't want to wait until right when they're on their deathbed," adds Ms. Malone. She suggests physicians to encourage families to stop in to the hospice office and investigate the program; knowledge helps them make decisions. In some cases where a physician is uncomfortable talking to a family about the terminal illness of a member, the hospice has sent its social worker to the doctor's office or patient's home for a meeting with the family.

"I do read the obits," Ms. Malone says, "and I know there are people dying at home. And my concern is: Why didn't we have them? But I realize hospice isn't for everybody, and some people do die suddenly."

Ms. Malone says because hospice is concerned with comfort and quality of life, the staff also helps patients look closely at the treatments they are undergoing, ask their physicians whether the treatments are genuinely beneficial, and weigh the effects against the kind of life they really want during the limited time they have left. She cites the example of a patient undergoing multiple rounds of chemotherapy because a physician "says to." The family and patient are "running" all the time between appointments; the travel and treatments often exhaust the patient. The hospice staff may gently suggest they save their energy for what they really need to do, spend their remaining time together or doing things the patient can still enjoy.

"There comes a time when you have to listen to the patient," Ms. Malone emphasizes. "Does he want all this [treatment] continued for ever and ever? They do have choices, and they can say 'no.' Wally had been confronted with near-death many times. He made a conscious decision not to go back in the hospital."

Listening well is only one aspect, Ms. Malone maintains. Physicians also need to understand their patients' education/comprehension levels and use terminology they can understand. "We've had referrals where a physician had told patients they are 'terminal.' We go to see the patient, and we find out the patient didn't know what 'terminal' meant, so the idea that he or she is dying is a surprise." Sometimes patients don't fully understand a diagnosis, she adds, because they are in awe of the physician, don't want to bother the doctor by asking questions, or have only heard what they want to hear.

The author is a Lansing-based freelance writer. Mr. Potter died comfortably in his home prior to the printing of this issue. Michigan Medicine wishes to thank him for participating in this article.

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Michael H. Dawson, MD

Injury helps physician appreciate patient's pain

By Ralph D. Ward

favorite popular culture focus on physicians has been the personal changes demanded when the doctor himself must navigate a health care crisis. From the book A Leg to Stand On by Oliver Sacks, MD, to William Hurt's 1991 film The Doctor, the trauma of a physician facing his own health crisis is presented as an experience both humbling and enlightening. However, Michael H. Dawson, MD, an orthopedist in solo practice in Adrian, knows this experience with far more personal immediacy and drama than any book or movie can share.

Doctor Dawson operates his own farm outside of Adrian. In January 1992 he was hard at work in an isolated field at a task familiar to many farm workers, unjamming a stuck piece of machinery. He was at work in the implement with his left hand, when suddenly his sleeve, hand and arm itself were dragged into the grinding jaws. Instantly, the orthopedist with a solo practice faced a solo orthopedics case of his own — and the stakes were his own life or death. Doctor Dawson recalls that the shock of having his arm crushed and trapped seemed to deaden the immediate pain, and help him weigh his situation. "Here I was, trapped by myself in a field in a machine. I had arterial damage as well. When I was standing, the blood would literally shoot out over my head. When I squatted down, that stopped the major bleeding, but I wasn't able to work on freeing my arm. So I would stand working to free my arm and bleeding for a few moments, and then squat down to rest, but all the time I was growing more and more tired, and I remember thinking 'well, it may all end here." The machinery had also torn off Dawson's shirt, leaving him bare from the waist up in the January chill.

After 25 minutes trapped in the field, Doctor Dawson was able to flag a passing motorist, who alerted paramedics. On arrival, he was able to extract his arm with a knife from paramedics, who then rushed him to the local hospital. "I recall ordering my own IV and antibiotics on arrival, but that's the last I remember." A fellow orthopedist and personal friend faced the tough call on how to treat the massive arm injury, but ultimately decided to amputate, a judgment that Doctor Dawson doesn't second guess. "The fellow who did the work is

a long-time friend whose decision I trust. The injury was so catastrophic that it was essentially a dead piece of flesh, so the fate of the arm was

Within a couple of days, the immediate crisis passed, Doctor Dawson found himself in bed, considering his options as an orthopedist without his left arm. "I tried to figure out how I could work now, what I could and couldn't do. I realized I could go back to doing [orthopedic] surgery with one arm, but I'd just be grandstanding, and a guy with two arms could still do the job better. It would have been meeting my ego needs, but not the patient's needs."

Doctor Dawson was "out of work" in his words for about three weeks, and returned to practice on a limited basis, though not to the operating room. "I can reduce simple fractures, and do orthopedic evaluations, such as shoulders and knees." Dawson wears a prosthesis, and many people, even some patients, are unaware that the doctor is missing an arm.

Today, Doctor Dawson continues his practice, seemingly recovered both physically and spiritually from his near-death trauma of five years ago. "The docs I was involved with thought I would become depressed, and even



Michael Dawson, MD, with patient, in his office.

had a psychiatrist set to talk with me. I was waiting for it to hit, but it never came. When the going gets tough, the tough get going."

Yet his ordeal has left deeper marks on this doctor. Pain in his stump continues, a daily reminder of what was lost. Perhaps this is part of the reason Doctor Dawson notes a change in the way he deals with patients today, as well as with the overall idea of mortality. "There is a little more empathy now. When I first came back, I realized I was taking a little more time with patients. Maybe I can better appreciate the pain and dysfunction they're trying to express now." Also, Dawson finds himself better able to speak with terminal patients, sharing a

secret language spoken only by those who have closely faced death. "There is a way to talk that didn't exist before.

"When a friend, a pastor, was dying of cancer, we could look each other in the eye, and there was an appreciation that we had both gone down the same road."

The author is a Riverdale-based freelance writer.

"There is a little more empathy now. When I first came back, I realized I was taking a little more time with patients. Maybe I can better appreciate the pain and dysfunction they're trying to express now."

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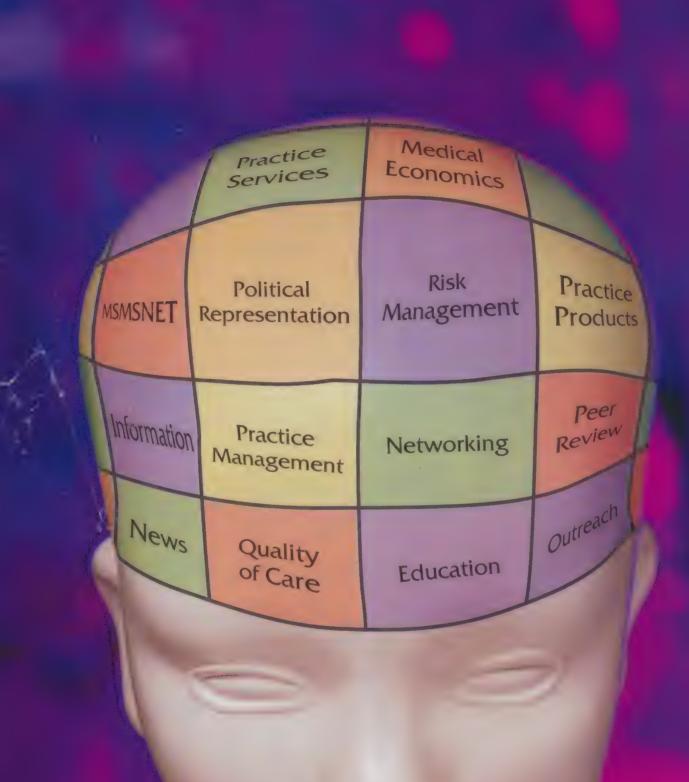
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Giving physicians a "head start" in today's changing practice

As the health care environment continues to change, and as physicians position themselves to shape and manage that change, membership in Michigan State Medical Society has never been more important.

MSMS, now more than 13,000 members strong, always has been on the forefront of change, anticipating developments and providing solutions. MSMS physicians have been the ones to lead the discussion as the practice of medicine evolves. They face new challenges head on, confident that they have the clout and the tools to do so.

MSMS physician leaders spent considerable time and effort on strategic planning recently. They identified key concerns of doctors across the state, and in all types of practice. Among the most important are the issues headlined in the following articles.

The bottom line: Doctors look to MSMS for the resources they need to remain in control.

'But it's not the money'

The real reasons why membership is so important



By Cathy O. Blight, MD

ecently I had some conversations with some physicians who had not yet renewed their memberships. The conversations went something like this:

"John, this is Cathy Blight. I'm calling because you didn't renew your medical society membership. Can you tell me why?

"Well Cathy, I got my renewal notice just about the same time Jack Kevorkian made the headlines in our local paper about 'helping' another patient. It make me mad that the medical society can't take a firm stand on this issue. Why, this man is out there killing people! The public expects us to lead the debate. It's not the money; but until you folks can get your act together, I'm just not belonging."

"Mary, why haven't you renewed?"

"Well Cathy, I'm a pathologist, just like you, and you know we have a really strong

national specialty society. They provide me with a lot of clout in Washington and do a great job with CME programs. It's not the money; but I just don't see the need to pay for duplicate services when they do such a great job."

"Bob, why haven't you renewed?"

"Hey, I'm a super-specialist at the U. I've written the book on QA in left earology. The medical society is a bunch of old fuddie-duddie GPs who are trying to keep us from facing the challenges of today's medicine. It's not the money; but when your medical society gets into the 21st century, maybe I'll think of joining again."

"Suresh, why?"

"I'm an IMG. I have special problems and concerns, better dealt with in my national ethnic organization. It's not the money: but I think I need a different advocate."

"Sheila, why?"

"Cathy, you know I'm a pediatrician. I'm only working part time because my kids are small and I'm trying to pay back my student loans. I really like what the medical society is doing with immunizations, their preventative health issues and some of their computer classes—but

quite honestly, it's the money. It's an aw-people realize the value that is there. ful big chunk to pay at one time, espemaybe when my kids are older and I'm working full time, I'll come back."



Reimbursement Ombusdman, Joyce Nuremberg speaks with a member.

There was a time in my career when I thought only one of these physicians was really telling the truth when they said "it's not the money." I believe the issue really is the money, and if we listen to what they are saying, they are telling us that they don't see a value in their dues dollars. It seems to me that our challenge is to bring value to the membership, or maybe help

MSMS is involved in many things. We are a cially with specialty society dues and all. vocal presence in the halls of our local legisla-I'm really sorry—I support all you do, but ture and in Washington D.C., sharing our expertise with our legislators to craft solutions to help our patients and our profession. A prime example is the Michigan Patient Protection Act,

vides services vou can use.

More than 100 physicians every month call the MSMS Reimbursement Ombudsman, Joyce Nurenberg. She counsels them on how to solve stubborn Third-party reimbursement problems, and when all other attempts fail, she cuts through the red tape herself on doctors' behalf.

Joyce's role is one aspect of a large effort on the part of MSMS to advocate for physicians when it comes to the business side of medicine. From working with health plans toward physician- and patient-friendly policies, to promoting the creation of a single, convenient credentialing form and assisting with contracting issues, MSMS is a comprehensive resource for physicians in any practice type.

Recognizing the impact the focus on utilization and costs has on the practice of medicine, MSMS has just launched the Michigan Institute for Medical Quality, a partnership to identify and develop programs that encourage the highest auality of care for the health dollar. This physician-directed effort will focus first on practice guidelines, perfor-

MSMS cuts through red tape, shapes policy and proof the new Institute will be of great value to individual physicians, and ultimately will benefit their patients, as well.

> MSMS examines trends and data on a number of fronts, in order to keep members in the driver's seat. Each year the medical society evaluates Michigan health plans and Michigan hospital financial data, and presents concise reports that gain wide attention. MSMS also has analyzed the health status of Michigan citizens, helping both physicians and policymakers to understand the specifici challenges we face. And MSMS has issued case study analyses of, among other issues, management services organizations and single specialty networks, giving physicians of heads up and a set of tools for managing their practices.

> On another front that benefits both physicians and pa tients, MSMS and MPMLC have teamed together to offer a full calendar of risk management programs for both physicians and their office staff. The new management ser vices organization, Michigan Medical Advantage, assists physician groups with contracting, data management and

Professional Credentials Verification Service handles the paperwork for physicians and hospitals and health plans reviewing candidates. Physician Service Group, another MSMS subsidiary, provides physicians with resources like office supplies, equipment leasing, billing services, long distance, car leasing and more. And MSMS' Group Insurance Trust provides health and dental insurance for physicians, their families and their employees.

- Reimbursement Ombudsman: Joyce Nurenberg at (517) 336-5722 or a inurenberg@msms.org.
- •Third Party Payers, Health Plan Evaluations: Mary Anne Ford at (517) 336-5721 or at maford@msms.org.
- Michigan Institute for Medical Quality, and Health ilester@msms.org.
- Risk Management Programs: Peggy Galloway at (517) 336-5729 or at pgalloway@msms.org.

- · Professional Credentials Verification Service: F. B. "Tom" Plasman at (517) 336-5715 or at tplasman@msms.org.
- Michigan Medical Advantage: Kevin Cawley at (517)
- Physician Service Group: Dawn Reha at (517) 336-7584 or at dreha@msms.ora.
- Group Insurance Trust: John Richards at (517) 336-7584 or at irichards@msms.org

Health insurance go-between

In 1987, MSMS developed Group Insursance Trust (GIT) following members' directives in which they expressed concern with how their personal insurance matters were being addressed by health insurance companies.

For members who purchase insurance through GIT, "they Status Data: Julie Lester at (517) 336-5768 or at never have to work with the insurance company again," said GIT staffer Susie McNea.

which passed and was signed into law last session. Working with a coalition of medical and patient advocacy groups, MPPA put the patient's rights

preserve the patient/physician relationship, as available.

itself as a private insurance company.

Scientific Meeting, Perinatal and Maternal Health Conference, economic seminars and Internet training. The Bioethics forums this year have culminated in a conference that had in-

Educationally, MSMS sponsors the Annual

well as track the progress of Blue Cross as it



MSMS President Peter A. Duhamel, MD; Congressman Dave Camp (R-Midland); Immediate Past President W. Peter McCabe, MD; and Managing Director Kevin A. Kelly meet in Washington D.C.

cian assisted suicide and genetic testing.

Jointly with the subsidiaries, there are risk management seminars and seminars on capi-

in the era of managed care at the forefront of tation. Travel programs continue to be best sellthe debate. MSMS will follow the transition of ers, and through the subsidiaries, member benthe Medicaid population into managed care to efits, such as health and dental insurance, are

What the medical society provides is the inmoves to become less regulated and establish frastructure within which all of these activities and many more can take place. None of us can do it ourselves. Think of the time and energy it would take to track and follow just one legislative issue, including the background work needed to develop a coherent position and the time to lobby all the appropriate parties to make ternationally known bioethicists discuss physia a difference. The infrastructure is there to bring together different ideas and interests.

But, although our medical societies are involved in a without a lot of

thoughtful input from our members. One of the seems to me that the smallest effort is to pay exciting aspects of being involved is being ex- your dues; but then, get involved to see that posed to the divergent, individual voices then those dues dollars are wisely spent. coming up with a solution for the good of our patients and profession. Through the House of society does is provide purely social functions Delegates or committees or teaching, it is the where you can meet with friends and complain, commitment of the individual member, ensuring that the system works for them. So, it seems est friends are those I've met through medical that we need not only to pay our dues dollars society functions, probably because we all are but also to invest some time and effort on dedicated to helping people at those times when each of our parts to get involved. There are they need our help and expertise. many active members who work for all. They



MSMS President-Elect Cathy O. Blight, MD; Camille Johnson, Arthritis Foundation; Debbie Arnold, Immune Deficiency Foundation/ lot of things, noth- MI Chapter and her son, Christopher at the Michigan Partners for ing can be done Patient Advocacy Meeting.

do it over and above the dues dollars that they pay. How much stronger and effective we would be if each of us dedicated just a little time to help. So, it

Finally, one of the things that your medical reminisce, plot or whatever. Some of my clos-

Physicians are heard on state and federal issues

MSMS' clout in our state and national capitols begins with the grassroots strength of its members. Physicians testify at hearings, visit with their lawmakers at MSMS-coordinated events, and call and write to them about issues affecting the practice of medicine.

Doctors' efforts have paid off, for example, with high level, face-to-face meetings in our nation's capitol about Medicare and protecting the physician-patient relationship; in the hard-won passage of the Michigan Patient Bill of Rights, and in the successful halt of an amendment that would have allowed optometrists to prescribe for glaucoma in this state. Currently MSMS is proactively monitoring the re-opening of PA 350, which governs BCBSM, as that decades-old legislation is analyzed and discussed in Lansing.

Challenges to the doctor-patient relationship and scope of practice are ongoing, so it's never been more important for physicians to take action. MSMS provides a number of entry points through which your voice can be heard on legislative issues. It can be as simple as a phone call.

Resources:

•State legislation: Greg Aronin at (517) 336-5739 or at garonin@msms.org.

• Federal legislation, Medicare: Kevin A. Kelly at (517) 336-5742 or at kkelly@msms.org

· Michigan Doctors Political Action Committee and Western Union telegram to lawmakers program: Donna LaGosh at (517) 336-5788 or a dlagosh@msms.org

Unity for physicians in a changing environment

MSMS is a unified voice that emerges from an inclusive, democratic process. There are a number of access points through which physicians may network and be heard including the House of Delegates, and the wide-ranging committees and task forces, where many MSMS initiatives

There are special forums within MSMS, as well, where articular concerns may be addressed, including sections or young physicians, organized medical staff members, ternational medical graduates. In addition, there are orums for women physicians, corporate affiliated physiians, residents and medical students.

MSMS Board of Directors and House of Delegates: William E. Madigan, Executive Director at 517-336-5734 or at wmadigan@msms.org.

ilester@msms.org.

International Medical Graduates Section and Committee on the Concerns of Women Physicians: Sherry Barnhart at (517) 336-5786 or at sbarnhart@msms.org.

Organized Medical Staff Section and Corporate Affiliated Physicians: F.B. "Tom" Plasman at (517) 336-5724 or at tplasman@msms.org.

 Young Physicians Section and Medical Students: Deborah Zannoth at (517) 336-5767 or at dzannoth@msms.org.

MSMS keeps doctors—and their staff—abreast of the science and business of medical practice

MSMS' Center for Education and Leadership is the new name for activity that has been a priority for the medical society since its inception: Education. Continuing medical education continues to be a major focus, and MSMS is finding new ways to deliver quality CME to physicians, including teleconference and online options. Several major Residents: Julie Lester at (517) 336-5768 or at conferences each year present top speakers and cutting edge subject matter—the MSMS Annual Scientific Meeting and Annual Conference on Maternal and Perinatal Health are the flagships of a strong scientific program.

> MSMS puts equal effort into presenting non-scientific education aimed at positioning physicians at the front of the curve when it comes to practicing in this changing environment. Topics like contracting, coding, quality, and

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So-my answers to my friends went something like this:

"John, you have hit on one of the hardest issues facing us today. As you must realize,

cian assisted suicide, there's one who is a strong supporter. So, I think it's important that we share ideas and concerns about this issue and others as they come up. But John, we can't do it unless every voice and viewpoint is heard. Which is why we need you to help us understand your ideas. Maybe it's not the money, but also the commitment of time and effort to ensure that you are adequately and accurately represented. You can't shape the debate if you're not at the table—think about it."



MSMS President Peter A. Duhamel, MD, and Alliance President Blanche Mindlin in Lansing at the 1997 Capitol Checkup.

"Mary, I agree with you about our national specialty society. They really are good, aren't they? But so many issues are closer to home such as the Michigan Patient

for every physician who feels like you on physi- Protection Act and the business with the Blues. They need our attention, maybe even more. We need folks like you to help integrate the national perspective with the local for everyone's benefit and help us look for ways to integrate those services."

> "Bob—what can I say? You definitely are one of the world's experts in left earology, everyone knows that. And I'm sorry we're not moving fast enough for you, but we're all a little resistant to change. Work with us, help us understand why these changes aren't necessarily bad

and how they may benefit all of our patients. Think about it, and who knows, maybe you'll pick up some new ideas, too,"

"Suresh, I know you have special concerns and

problems. We all see the world differently, and perfect. So we need to work to make them more we need to share our individual view of the so. We need to remember why we all went into world. By working with a larger, more divergent medicine in the first place—to help people. group, you can gain support and help with your Ours is a healing profession and the core is the individual problems. And, you can add your individual physician/patient relationship. If we support to those issues that we all share in com- can keep that vision then we need to strive to mon."

things are and I appreciate your support. We'll time and commitment. Will you help? continue to work on innovative ways to ensure that all our voices will be heard and in an af- Doctor Blight is president-elect of MSMS.



MSMS President Peter A. Duhamel, MD; Chairman of Bioethic committee, Howard Brody, MD, PhD; Speaker and chair of the AMA Board of Trustees Thomas R. Reardon, MD; Cchair of MSMS Board of Directors Krishna K. Sawhney, MD and speaker David Doukas, MD, gather at the 1997 Conference on Bioethics.

fordable way. I'm sorry I can't be more optimistic right now, but we'll keep working at

I realize all this may sound simplistic. But our medical societies aren't

construct and mold a medical society that can "Sheila, what can I say? I know how tight support and nurture it. But it takes dues and

computers and the Internet are among the regular offerings. New in 1998: MSMS will launch a training and certification program for medical office staff members, helping Michigan physicians to recruit and retain qualified personnel.

Resources:

- Continuing Medical Education, Annual Scientific Meeting, Maternal Health Conference: James Tarrant at (517) 336-7591 or at jtarrant@msms.org.
- Non-clinical Educational Opportunities: Mary Jensen at (517) 336-5706 or miensen2@msms.org.
- Medical Office Staff Training and Certification: Deborah Zannoth at (517) 336-5767 or dzannoth@msms.org.
- •Internet Training: William DeCourcy at (517) 336-7604 or at wdecourcy@msms.org.

Training physicians and office staff

While doctors will be able to learn how to effectively represent themselves in today's socioeconomic market, office staff members may learn communication skills, spe-

cialty coding procedures, new medical terminology and trusted source. MSMS provides physicians with the skills shop may become members of the Physician Communica-Occupation of Safety and Health Association (OSHA) regulations, according to Deborah Zannoth, MSMS chief of professional development—who will work closely with the Resources: Michigan Medical Group Managers Association, to establish these training courses. Staff members who complete training about such issues will be licensed medical business specialists.

MSMS works with the media, the public and opinion leaders

Every day, the headlines report changes in the health care environment, so MSMS is at work on many fronts to represent physicians, clarify their role as leaders on all health-related issues, and to promote good patient relations. MSMS works closely with the AMA to represent doctors on a national scale, and with county medical societies to project the physician's voice at the local level.

MSMS physicians themselves are the profession's best spokespersons, keeping the public informed by a most

and opportunities needed for them to take on that role.

- •Communications: Sheri Greenhoe at (517) 336-7603 or at sgreenhoe@msms.org.
- Publications: Judy Marr at (517) 336-5744 or at imarr@msms.org.
- Leadership and Media Training, Public Relations, Federation Planning: Dave Fox at (517) 336-5731 or at dkfox@msms.org.

Media Savvy

As manager of media relations, David Fox offers doctors guidance as to how they may work with the media to express their messages.

Doctors may participate in a workshop during which hey will get suggestions on speaking with or writing to broadcast and print media. Those who complete the work-

tion Network, and may speak on MSMS' position on such topics as physician-assisted suicide and managed health

Fox also helps physicians who haven't completed the workshops. He prepares doctors for what types of questions to expect, briefs physicians as to the possible answers and offers some background information about the reporter's interview style.

These types of requests for help are common, according to Fox, who said he receives a call like this from various doctors about every other week. He recognizes the dialogue between the media and MSMS members as important because "physicians are a very credible voice in their local communities and it is important to get their comments and opinions in their local media."

"Any member should feel free to call me if they need help working with the media."

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Heads up—Here's what's coming at you in economics and legislation

In addition to the clout and tools of MSMS, anticipating upcoming changes also is valuable to members. An analysis of the changes coming in the economics of medicine follows—providing you with a heads up and an overview of MSMS resources available to you. A close look at emerging issues at the state capitol follows, explaining how the dynamics of the coming legislative session may affect the practice of medicine.

Surprise—More managed care ahead

By Mary Anne Ford, MSMS director, department of medical economics and health care delivery.

MSMS predicts the following developments in Michigan physicians futures. Strategies, plans and programs are prepared to help you drive your practice successfully through these events and developments. Read on to prepare yourself with advanced knowledge.

Enrollment in managed care plans will continue to grow, fueled by the Medicaid managed care initiative, Medicare managed care plans and innovative efforts by employers to steer employees into managed care plans.

Physicians' perceptions of quality in different health plans will become an increasing focus of quality measurement efforts. The MEDSTAT Quality Catalyst a joint venture with the New England Medical Center and JD Power and Associates, includes surveys of patient, physician and purchaser satisfaction with health plans in six pilot sites, including the Detroit and Lansing areas. In 1998, new sites will be added, including Grand Rapids.

Why the interest in what physicians think? Bruce Bradley, Director of Managed Care for General Motors recently told the MSMS Board of Directors that strong physician leadership is the best predictor of quality in a health plan. Physicians are in a position to judge how administrative requirements and financial incentives affect patient care, and purchasers will increasingly use measures of physician satisfaction in contract decisions.

Hopefully, physicians will take a cue from purchasers and become more selective about their contract decisions. MSMS will continue to provide tools to help physicians make sound decisions, including evaluation of health plans' financial stability, measures of patient and physician satisfaction, and enhanced contract assistance.

The national Resource Based Relative Value Scale (RBRVS) will continue to set the course in fee-for-service programs, including PPOs that use a discounted fee schedule. A Health Care Financing Administration analysis forecasts the impact of changes in the Medicare conversion factor and new practice expense provisions to reduce physician net

income by as much as three percent for some specialties and increase it by the same amount for others. Specialists evaluating the impact of these changes will find the Case Study Analysis of Single Specialty Physician Networks, cosponsored by MSMS, the AMA and six national specialty societies a valuable source for information about new options.

Single specialty networks, physician organizations and physician hospital organizations will have new opportunities and challenges. The National Committee on Quality Assurance this year released draft standards to certify Physician Organizations and Physician Hospital Organizations. Following a pilot study, NCQA plans used to certify organizations seeking delegation of credentialing, utilization management and quality assurance functions. In Michigan, Senate bill 732 would provide immunity for peer review activities conducted by group practices and physician organizations. Recent adoption by the Michigan Association of Health Plans of a common credentialing form clears hurdles for physician groups seeking authority to handle their own credentialing.

New Medicare laws pave the way for "provider sponsored organizations" (PSOs) to directly contract for care of Medicare beneficiaries. The Congressional Budget Office assumes that more than three million Medicare beneficiaries will enroll in PSOs by the year 2002, but not before federal and state regulators define PSOs and their solvency and licensure requirements. Medicare involvement in direct contracting could establish a framework for other direct contracting opportunities. MSMS plans discussions with the state Insurance Commissioner to influence Michigan regulatory decisions, while the AMA remains an active player in setting federal standards.

Legislation to convert Michigan's largest payer, Blue Cross and Blue Shield of Michigan, to a non-profit mutual insurer will draw attention to many important issues. MSMS was a leader in passage of the Michigan Patient Protection Act, effective October 1, but questions persist about underwriting practices and exclusion from insurance of people with preexisting medical conditions. Although it is

"Strong
physician
leadership is
the best
predictor of
quality in a
health plan."
Bruce Bradley

General Motors

likely that Blue Cross and Blue Shield of Michigan will continue its role as an insurer of last resort, new questions about uneven playing fields will be debated.

The legislative debate about Blue Cross and Blue Shield regulation gives MSMS a unique opportunity to raise concerns about policies and practices affecting physicians. MSMS will initiate Blue Cross Blue Shield legislation to address payment for physician-owned freestanding surgical centers, utilization management practices and due process for physicians who appeal BCBSM decisions.

Term limits will force repositioning

By Greg Aronin, MSMS director of government relations To successfully impact the legislative process, advocates must understand that legislative trends are based on the demands of society, the demands of special interest organizations and the pressures of politics. Advocates must also understand the environment in which policy is developed. In 1992, Michigan voters passed a state-wide referendum to establish term limits. These term limits include three two-year terms for House of Representative members and two four-year terms for state Senators accumulated from January 1, 1993. Based on these term limits, the state of Michigan will have at least 67 new state representatives in 1998.

This creates a scenario where lawmakers position themselves for the next step in life, whether it be seeking another political office, such as state senate or congress, attorney general, county commissioner, drain commissioner, etc. or a job in the private sector. This consistent positioning on behalf of lawmakers is further complicated by the extensive positioning of special-interest organizations in Lansing. Many organizations are still trying to figure out what their role in the legislative/political arena will be under term limits, how they are going to succeed quickly at getting to know 70 new lawmakers or how they are going to get to know the hundreds—or possibly thousands—of candidates for state offices, and where their energy should be focused in seeking their agendas once this new scenario takes place.

There are many trends that will emerge as a result of the demands of society and the demands of special interest organizations, but these demands will continue to be affected by this consistent repositioning until individuals can settle into this new mode of political reality.

As managed care has become more prevalent in the Michigan health care marketplace, lawmakers and special interest organizations have responded by seeking legislation that would establish standards for managed care and insurance organizations. Lawmakers also have responded with the desire to mandate coverage of certain benefits and to insure that insurance companies and managed care organizations have truth-in-lending policies. It is likely that this trend will continue.

The response to special interest organizations' objectives in seeking increased scope of practice will continue. Currently, legislation that will expand the scope of practice for optometrists in Michigan is moving forward, which will allow them to treat glaucoma using anti-glaucoma medication. This legislation is strongly opposed by MSMS and the Michigan Ophthalmological Society; however, the Michigan Optometric Association has been working on it for years. It recently passed the Senate and is expected to be taken up in the Michigan House in late October. Nurses will continue to seek the ability to prescribe medication independent of physician supervision or physician collaboration. Chiropractors will continue their efforts to expand their scope of practice. Whether it will become more difficult or easier for this legislation to pass is difficult to tell. One may argue that some lawmakers have supported scope-of-practice legislation as a result of pressure built up over many years of lobbying by these special interest organizations on a single issue, and that under term limits, this same pressure will not build.

Lawmakers will continue to attempt to fill gaps wherever problems exist in medical advancement. For example, many lawmakers are interested in seeking legislation that will establish requirements for pain management facilities and providers of pain management. This is due to their belief that access to pain management services in Michigan is somehow limited. The debate over pain management will continue to exist, especially as long as physician assisted suicide is an issue. However, it is likely that in several years a similar issue will evolve regarding a perceived lag between the demands of society and medical technology. Already a bill has been introduced to mandate certain aspects of infant pain management.

While these trends are in force, MSMS creates its own trends, by organizing coalitions, by responding appropriately to new trends and most importantly by preparing the physicians of Michigan for life under term limits. The new political reality will require physicians in Michigan to be active at the local level. Physicians will have greater impact on policy and politics in the state of Michigan by being involved in their communities. Physicians will have a greater opportunity to run for office and be successful or to give input to new lawmakers and have them accept that input. The most important thing is for physicians to become involved.

1997 Peer-to-Peer campaign

Reach out and recruit

By Louis R. Zako, MD

I want to personally thank all recruiters who participated in the 1997 "Reach Out and Recruit," peer-to-peer membership campaign. Active participation in this important activity has assured the continued success and growth of membership in our society. MSMS is very fortunate to be one of the few states in the federation that has grown steadily over the past few years.

I am pleased to announce that Edward Cohn, MD, a neuro-ophthalmologist from Royal Oak, is the grand prize winner! Doctor Cohn is chair of the Membership Committee for the Oakland County Medical Society. As a result of his dynamic efforts he wins two round trip tickets to anywhere in the continental United States. He personally recruited and sponsored five new MSMS members in 1997. These five new members resulted in a total of \$3,525 for MSMS and OCMS and if the members remain a part of organized medicine for at least 10 years (which is the average) the grand total of funds for the societies would be \$35,520.

Doctor Cohn's success in recruiting new members for organized medicine allowed the Oakland County Medical Society to be the big winner in the county medical society category. OCMS grew by seven percent in 1997—a total of 131 new members. Doctor Cohn's methods

obviously are quite effective. I understand that he sends out letters and then follows up with physicians personally. He talks with them in the hospital, restaurants—anywhere he encounters a non-member, and he isn't shy about discussing the benefits of organized medicine.

Again, I cannot say enough to those who participated in the

1997 "Reach Out and Recruit" campaign. The personal endorsement of a current member is by far the most effective method for recruiting nonmembers. It is only in this way that individual physicians will help organized medicine grow and enrich our professional development as well.

You soon will be receiving information about the MSMS peer-to-peer campaign for 1998. Please take time to read the materials and become actively involved. Increased membership will enhance the strength of organized medicine in Michigan. Other beneficiaries include our patients, whose access to quality health care will be assured only if physicians speak loudly and forcefully as advocates for them.

The author is chair, MSMS Committee on Recruitment and Retention

The following members have won awards from the AMA for their recruitment efforts and will be honored at the AMA Annual Meeting:

Tama D. Abel, MD Busharat Ahmad, MD Hassan Amirikia, MD Gilbert B. Bluhm, MD Robert G. Borchak, MD Nitin C. Doshi, MD Carl F. Hammerstrom, MD Alan M. Mindlin, MD Sherma Narinder, MD Krishna K. Sawhney, MD B. David Wilson, MD



James L. McGauley, MD

Getting it all together on patient information

By Ralph D. Ward

In an age of exploding computer online and database technology, it would seem that medical practices must suffer from information overload (an idea with which many office administrators would heartily agree). But what if the problem were in fact the opposite — too little comprehensive information on patients, disguised among a welter of duplicative, hard to manage medical record systems? James L. McGauley, MD, formerly a practicing neurosurgeon in Southeast Michigan, traces his new second career as an entrepreneur to the moment he asked that question.

Doctor McGauley recalls that when in practice, he was "frustrated that patient records were rarely coordinated, or even available when seeing patients, and that doesn't seem to have improved." He set to thinking about the scope of the problem — and potential solutions. "I think the focus of information systems out there, those that even have a focus, is on pulling together parts of records, but not to coordinating the different pieces." A combined interest in medicine and computers helped Doctor McGauley gauge how technology could be used to help the situation. "We need more of a focus on coordinating the [patient] information generated rather than just computerizing." For example, if a primary care physician's patient visits another physician, the records might get back to the primary care doctor — or they might not. "And if the patient visits an emergency room, the info may just sit in the hospital's computer system."

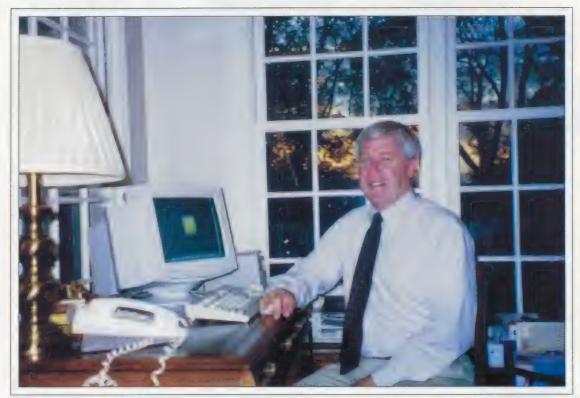
What if, Doctor McGauley wondered, a central nexus could collect this data, and make it available to those who need it, particularly patients, physicians, purchasers and payers? The network might me limited and local at first, but could expand with success. Rather than just daydream, however, Doctor McGauley set to work for developing a model for such informa-

tion gathering that could work in the real world of health care. "Our model is the banking industry.

Think of credit cards or ATM cards. The customer carries the card to the point of service, and everywhere he or she goes in the service area, physicians, clinics, labs, pharmacies, the information is sent to a central station. A coordinated record is generated, like the coordinated bank statements we get now."

In 1994, Doctor McGauley formed a company in Ann Arbor to develop the program, called Medcard Systems Inc. He is currently negotiating with several area physician groups and purchaser alliances to implement the plan. Patients will be issued a "smart card," capable of storing basic information, and will then "almost be able to use it as a debit card for health care. Then, via the internet, our regional network will pull together the diagnoses and records from the physician's offices [for the patient], plus labs and pharmacies." The information is then made available to the physician. A far more comprehensive record than is now available will be created. "People get their health care regionally." Confidentiality is assured through up to 20 levels of security features and protocols.

Interest in the Medcard program is growing, says Doctor McGauley, due to the wide benefits to all players in health care. "PHOs and large physician groups are interested, but it's also logical for purchasers themselves, employers and the government. Essentially we create a regional health care network, yet it remains a very patient-centered system. While our program empowers the patient to start with, it also empowers physicians, while allowing them to document the quality of their care and justify their costs." As to physician office administrative



Doctor McGauley, at his home in Ann Arbor, MI.

burdens, the Medcard system "not only doesn't require more time, it requires less. This really relieves a lot of the billing burdens."

And how does the physician feel about his new career as an entrepreneur?

"I'm still very health care oriented, and I can now help a lot more people than I could as a neurosurgeon. Life is short, and I still have a lot of things to do."

The author is a Riverdale-based freelance writer.

"I think the focus of information systems out there, those that even have a focus, is on pulling together parts of records, but not to coordinating the different pieces."

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Jaak M. Pahn, MD Sault Ste, Marie



Willard S. Stawski, MD Grand Rapids



Howard Comstock, MD
East Lansing



Steven G. Fettinger, MD
Saginaw

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Patient Bill of Rights Act becomes law



Michigan Partners for Patient Advocacy meeting October 1, 1997, at the Radisson Hotel in Lansing celebrate the effective date of the Michigan Patient Bill of Rights. MSMS lobbied long and hard with the MPPA for passage of the bill.



June Knapp, a cancer survivor and speaker for MPPA, chats with Representative A. T. Frank (D-Saginaw).

1997 Bioethics Conference— Mackinac Island, Grand Hotel

On September 26-28, 1997 MSMS presented its first Annual International Mackinac Island Conference on Bioethics. Participants gathered at the Grand Hotel to discuss physician assisted suicide and genetic testing-among other tipics.

See the December issue of Michigan Medicine for complete coverage of the Bioethics Conference!



Timothy E. Quill, MD, Professor, Medicine of Psychiatry, University of Rochester School of Medicine; Thomas R. Reardon, MD, chair of AMA Board of Trustees and Raanan Gillon, editor, Journal of Medical Ethics, MBBS, FRCP address participants of the Bioethics Conference.

The Mother I knew

A personal tribute to Mother Theresa

By Raj Bothra, MD

he world recently witnessed the passing of two extraordinary women—Mother Theresa and Princess Diana.

I did not know Princess Diana, but I did know the Mother. Our first meeting was in an orphanage in Bombay in the mid-eighties, when we discussed the issue of drugs in India and also a plan about setting up a shelter for the dying and destitute—something akin to hospice in the United States. I will never forget the moment when I first met and touched the Mother. Pammi, my wife, said it was like touching God.

Every moment and her every expression had something to do with compassion for the poorest of the poor. I saw all around the little orphans not only getting shelter but love. We came out with the feeling that there is more to life. The scriptures say "More blessed are those who give than who receive."

Over the last decade or more, I had the opportunity of working with Mother Theresa on many other issues including AIDS. In India, where there are more HIV positive people than anywhere else in the world, and where the fright and ignorance is so palpable, the sight of Mother Theresa touching and hugging a child with the HIV virus perhaps did

more than any scientific advance or government program in the last decade.

The legacy of the Mother will go on for ever in the shelters, the orphanages, in the caring of the sick—drugs, AIDS, leprosy—and the hospices. Her work extended more than half a century in Calcutta and all over the world.

There are several stories about Mother Theresa but I will touch on two. A visiting cardinal who saw the Mother caring for a dirty, infected wound of a poor man in Calcutta remarked, "I wouldn't do it for \$100.00." Mother Theresa said, "I wouldn't do it either for \$100.00, I do it for Jesus." Ronald Reagan, while presenting the

Medal of Freedom, the highest U.S. civilian honor, said Mother Theresa would probably melt the gold medal and sell it to serve the poor.

Common law of the Vatican postulates a waiting period of five years after the death of a person to reflect upon the life of that individual for declaring "sainthood." When the enthusiasm of the moment passes, history will correctly judge the contribution of the two extraordinary



Raj Bothra, MD, and his wife, Pammi, speak with Mother Theresa in Calcutta, India.

women that recently passed away.

On a personal note, I will always see the Mother in my little daughter, now eight, who was given to me by her orphanage when she was six months old.

In this century if anyone ever deserved "sainthood," it has to be Mother Theresa.

The author is a Warren-based surgeon.



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Truths and myths

Narcotic medication usage for pain management

By Mark L. Gostine, MD

ack Kevorkian's role in physician-assisted suicides has thrust the use of narcotic medication for patients suffering from non-cancer pain into the national spotlight. It follows that those medical doctors who do not believe in physician-assisted suicides need to provide their patients with an alternative form of effective pain control, which in some cases includes narcotic maintenance. As a result, this is a good time to review some basic concepts that have proven beneficial in the treatment and case management of patients suffering from painful conditions.

Physician Concerns

Many physicians primarily are concerned about the possibility of addiction in their patients on chronic narcotic analgesia. In reality, doctors may be confusing addiction with drug dependence. Drug dependence is the physiological change that occurs in any individual placed on long-term narcotic analgesia. If someone is drug-dependent, they will go into withdrawal when the narcotic medication ceases, unless the drug is tapered.

Addiction, on the other hand, is a psychological phenomenon defined by aberrant behavior in the search of narcotic or other euphoria-inducing medications. This behavior frequently involves repugnant or criminal activities.

It is important to remember that the vast majority of patients who are drugdependent are not addicts. They are not engaging in the type of behavior that society frowns upon because of their dependence on narcotic medications. Indeed, in a properly con-

Addressing the pain

By Fred N. Davis, MD, and Daniel M. Mankoff, MD

Chronic pain spans many disease processes

Almost every doctor will treat patients that suffer from painful conditions. Therefore, physicians need to be cognizant of advancements in pain management for the successful delivery of coordinated and integrated pain care for their patients. Pain management and the care of pain patients spans the complete range of medical disciplines and it supports and works in conjunction with initiatives such as rehabilitation, industrial medicine, occupational therapy and psychiatry.

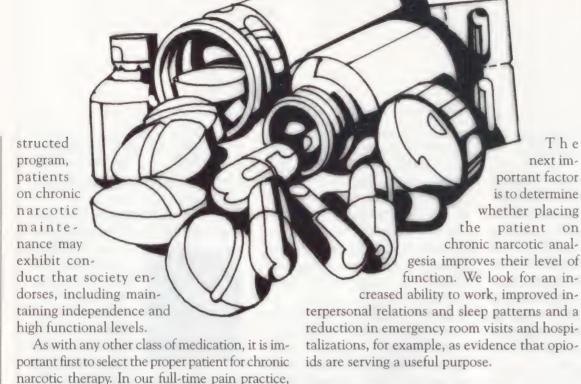
Surprising Statistics

•As of 1980, acute and chronic pain were estimated to cost the U.S. economy more than \$90 billion per year.

 Data from the National Institute of Health indicates that as many as 15 million adults suffer from lower-back pain with a minimum cost of \$5 billion in direct medical costs and 93 million work days lost every vear.

Development of Comprehensive Pain Management Centers in Response to Need

Over the past 20 years, clinics have been established to accommodate the diagnosis and treatment of acute and chronic pain through the development of comprehensive pain management centers. Currently, pain management centers are found in both uni-



Control over narcotic therapy

The final step in treating a patient with narcotics is to ensure that the patient is not acting as an addict. We require patients on chronic narcotic therapy to adhere to a code of behav-

continued on page 55

It is important to remember that the vast majority of patients who are drugdependent are not addicts.

versity and community hospitals, as well as free standing facilities. The 1996 American Pain Society Directory of Pain Management Facilities lists approximately 350 entries, and this number is expected to climb considerably over the next ten years.

we like to see objective evidence of an underlying

painful condition. Lacking objective radiographic

evidence, the consistency of the history and the

patient's behavior are paramount. This is because

some chronic painful conditions, such as head-

aches, cannot objectively be verified.

A Multidisciplinary Approach is Key to the Future

Successful pain management practices of the future must employ a combination of the following characteristics in an effort to ensure the delivery of the best care possible, including:

- · Close collaboration with referring physicians for enhanced case management.
- Increased knowledge of the patient's concomitant medical and social factors.
- ·Close working relationships with behavioral medicine.

- Accessibility of rehabilitation resources.
- The ability to provide a variety of medicinal and invasive pain treatment techniques.
- •Use of nerve block techniques in addition to more advanced treatment techniques.

Pain management is an integral part of health care whether the need arises out of a terminal illness, short-term accident or chronic health problem. It is increasingly important for medical professionals to realize that if pain cannot be abated, then the physiological, psychological and social consequences of pain patients must be minimized.

Doctor Davis is vice-president, partner and cofounder of Michigan Pain Consultants. Doctor Mankoff is a partner of MPC.

NEWSMAKERS

Bruce Becker, MD, vice president of Medical Affairs at the Rehabilitation Institute of Michigan and associate professor at Wayne State University, recently co-authored a book entitled Comprehensive Aquatic Therapy. Along with his co-author Andrew Cole, MD, Doctor Becker, of Detroit, describes the science behind aquatic therapy's healing effects and how it is used to treat various illnesses and injuries.

Ramsay Francis Dass, MD, PC, was recently elected president of the board of directors for Renaissance Hospital and Medical Centers. Doctor Dass, of Oak Park, is also medical director for the hospital's Oak Park Medical Clinic.

Richard D. Judge, MD, FACP; Jan Rival, MD, FACP; David R. Rovner, MD, FACP and Francis M. Wilson, MD, FACP, (below) recently were awarded the 1997 Michigan Laureate Award from the Michigan Chapter of the American College of Physicians. The award honors their long-standing and loyal support and distinguished service of the American College of Physicians

Charles Main, MD, chief of Pediatric Hematology/Oncology at William Beaumont Hospital, Royal Oak and Mark D. Rosenblum, MD, chair of the department of neurosurgery at Henry Ford Hospital, have recently received the American Cancer Society Achievement Award.

Sanjay Gupta, MD, an Ann Arbor neurosurgery resident at the University of Michigan Medical Center, is among 15 people who recently were selected as White House Fellows. Doctor Gupta will serve as a full-time paid assistant to cabinet secretaries, senior White House staff and heads of executive branch agencies.

Malek Hedayat, MD, recently was selected as director of Mount Clemens General Hospital's new outpatient cardiology diagnostic center in Sterling Heights. Doctor Hedayat, of Roseville, is a clinical instructor at Wayne State University and a diplomat of the American Board of Internal Medicine and the American Board of Cardiovascular Diseases.

Mary Elizabeth Roth, MD, MSA, was appointed president of the

Michigan Academy of Family Physicians. Doctor Roth, of Southfield, is the second woman in the Academy's history to achieve this position. She is also the chairperson of the Department of Family Practice at Providence Hospital and clini-

cal professor for the Department of Family Practice at the Wayne State University School of Medicine.

William A. Conway, Jr., MD, vice chair of the Henry Ford Medical



Group, has been elected president-elect of the American Medical Group Association. Doctor Conway, of Birmingham, had

held the position of treasurer of the association from 1996-97. In addition, Doctor Conway is the chief medical officer for Henry Ford Health System-Detroit region, vice president of Professional Staff Services and member of the Henry Ford Health System's Office of the President.

Susan Sevensma, DO, and Max T. McKinney, DO, FACOFP, were each recently named 1997 Physician of the Year by the Michigan Association of Family Physicians, Inc. Doctor Sevensma, of Grand Rapids, teaches residents at Metropolitan Hospital. Doctor McKinney, a Farmington Hills family practitioner, is president of the Michigan Osteopathic Association.

Warren Brandes, DO, assistant clinical professor at the Michigan State University's College of Osteopathic Medicine and College of Osteopathic Medicine of the Pacific, was elected president of the American Osteopathic College of Otolaryngology, Head and Neck Surgery. Doctor Brandes, of East Lansing, is



also a board member of the National Institute of Health.

Michael D. Seidman, MD, will receive the Honor Award from the American Academy of Otolarvngology's Head and Neck Surgery Foundation. Doctor Seidman is a West Bloomfield otolaryngologist with Henry Ford Hospital.

Henry W. Lim, MD, was appointed chair of the department of Dermatology at Henry Ford Health System. Previously, Doctor Lim was a professor of dermatology at the New York University School of Medicine and was chief of staff at New York Veterans Affairs Medical Center. In 1995, Doctor Lim was listed in "The Best Doctors in America: 1994-95" as one of the 12 best doctors for dermatologic photobiology.

OBITUARIES

Frederick W. Brown, MD, died on March 7, 1997. He was 81. A Lansing family practitioner, Doctor Brown graduated from Wayne State University Schoolof Medicine. He served in the Army from 1942-46, and was also a member of the "Flying Physicians" group. Doctor Brown was a member of the Southern Medical Society, Aerospace Medical Society, Industrial Medical Society, Ingham County Medical Society, AMA and MSMS.

Donald V. Sargent, MD, died on June 29, 1997. He was 86. Doctor Sargent, a Saginaw obstetrician and gynecologist, graduated from Loyola University Medical School. He was a member of Phi Chi Medical Fraternity, the Rotary Club, the Michigan Society of Obstetrics and Gynecology and MSMS.

John R. King, MD, died on July 11, 1997. He was 82. A Monroe dermatologist, Doctor King graduated from the University of Minnesota Medical School. He was a past president of the Monroe County Medical Society, a member of Alpha Kappa Kappa Medical Fraternity, the Detroit Dermatology Society and MSMS.

Amos P. Rawson, MD, died on July 1, 1997. He was 91. Doctor Rawson graduated from the University of Michigan Medical School. He was a member of the Army Air Corps from 1942-46, and practiced tropical medicine as a missionary doctor in Burundi, Africa for 25 years. Doctor Rawson, upon returning to his hometown, Addison, served as the team doctor for the Addison High School football team. He was a member of the Lenawee County Medical Society, MSMS and AMA.

Paul DeVito, MD, died on June 16, 1997. He was 46. A Lansing orthopedic surgeon, Doctor DeVito graduated from the University of Michigan Medical School. He was a member of Phi Beta Kappa Honorary Fraternity, the University of Michigan Orthopedic Society, the Ingham County Medical Society, MSMS and AMA.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Avad E. Abrou, W Bloomfield Basma Abu-Ashour, MD, Monroe Clemenceau T. Acquaye, Detroit Alexis R. Adkins, Ann Arbor Sami R. Akkary, MD, Southfield Jesse Amezaga, Ann Arbor Aaron Anderson, Ann Arbor Kevin C. Anderson, Ann Arbor Alisha Arora, Ann Arbor Kaveh Aslani, W. Bloomfield Vijak Avasanonda, Grosse Pte. Park Meera Bajwa, Ann Arbor Steven D. Bastian, Northville Roy Belville, Ann Arbor Egle E. Berzinskas Weller, Dearborn Anne Betz, Ybsilanti Carrie L. Beu, Royal Oak Nicole R. Bibbee, Detroit Brian Billings, Grosse Pte. Park Paul J. Bock, Ann Arbor Anne Bolyard, Lincoln Park D. Dirk Bonnema, Detroit Iulie M. Bourbonnais, Madison Hts. Laurence A. Boxer, MD, Ann Arbor Nathaniel Brackett, Ann Arbor Amy Bradfield-McIntosh, Lansing Timothy N. Brundage, Detroit David Bruining, Holt Joshua Buckler, Ann Arbor B. Todd Burks, Ann Arbor

Daniel F. Cahill, MD, Ypsilanti Erica L. Canales, Okemos Mark R. Carey, Lansing Catherine Carretero, Birmingham Randy Ceton, Detroit Abigail E. Chaffin, Northville Shalini Chandra, Detroit Shiva Chandrasekaran, Ann Arbor Irwin Chow, Ann Arbor Betty Chu, MD, Royal Oak Lisa Chu, Ann Arbor Joy Coleman, Ann Arbor W. Charles Conway, Detroit Amy M. Cooper, Southgate Marco Corridore, Ann Arbor Jeffrey J. Critchfield, Royal Oak Trina E. Curlee Martin, Roseville Brandon M. Dalziel, Northville Stephanie Davis, Sturgis Ganesh R. Deshmukh, MD, Dearborn Timothy J. Dey, Dearborn Heights Paul J. Dibble, Detroit Richard R. Dopp, Ann Arbor Mohanpal S. Dulai, Sterling Heights Amy Edwards, Ann Arbor Kristen M. Eisbrenner-Curleh, Ann Arbor Khaled El-Hoshy, MD, Birmingham Stephanie A. Eschamilla, Lansing Tiffany Farchione, Southgate Sandra V. Fernandez, Ann Arbor Michele Fliss, Canton Adam Folbe, Birmingham Reason A. Ford, Milford Randolph S. Fung, Ann Arbor William J. Gabriel, MD, Ann Arbor Thomas A. Gaffey, Ann Arbor Jeffrey Gaines, Ann Arbor Manish Garg, Detroit

Matthew M. Burton, Ann Arbor

Alvsia L. Green, Detroit Harpreet S. Grewal, Ann Arbor Marney Gundlach, Ann Arbor Padma Guthikonda, Ann Arbor Heidi Haapala, Ann Arbor Wendy Haas, Farmington Hills Steven Haase, MD, Ann Arbor Peter M. Hammer, Farmington Hills Albert Harris, Ann Arbor Anthony F. Harris, Southfield William Harris, East Lansing Scott Haule, Madison Heights Brian J. Haworth, Ann Arbor Sarah Hazan, Bloomfield Hills Bettina Herbert, Okemos Carlos E. Hernandez, Ann Arbor Jeffrey C. Ho, Ann Arbor Amanda Holen, Ann Arbor Christopher J. Hummel, Okemos Jocelyn Huang, Ann Arbor Lynn Huffman, Ann Arbor Jeffrey S. Huo, Ann Arbor Jeffrey D. Hyland, South Lyon Rajeev K. Jain, East Lansing Lynn M. Jacoby, Ann Arbor Michele Johnson, East Lansing Stephanie Johnson, Okemos Angela N. Jones, Lansing Kathryn Jordan, Ann Arbor Sean Josephs, East Lansing Nikhil Joshi, Okemos Reza Kafi, Ann Arbor Helen Kang, Ann Arbor Jennifer Kaplan, Royal Oak Becky A Karbowski, Detroit Kristy Keller, Ann Arbor Rami R. Khoury, Livonia Carl Kim, Bloomfield Hills Paul J. Kinde, Detroit Dirk Kiner, Dearborn Michael K. Kirby, Lincoln Park Genoveva Knifong, Ann Arbor Ladia M. Koester, Woodhaven Elizabeth I. Krenz, Farmington Hills Irene Krokos, Sterling Heights Ionathan Kroll, Ann Arbor Beth Kurt, Haslett Jennifer LaCourse, Ferndale Nora Labiano-Abello, Detroit Vie T. Lam, Southgate David Lau, Beverly Hills Jacalyn Lesser, W. Bloomfield Jimmy M. Liao, Ann Arbor Ann Little, Huntington Woods Robert Long, MD, Troy Dave Loomba, East Lansing William M. Lopez, MD, Owosso Mohan Madala, East Lansing Raymond G. Magauran, MD, Ypsilanti Ayesha Mahmood, Farmington Hills Anu Malani, Okemos Jeff Martus, Ann Arbor Estrella Matyas, Ann Arbor Allan Mayer, MD, Sturgis Mike McDermott, Mason Andrew J. McGown, Detroit Kelly McLean, Ann Arbor Sarah E. McMillan, East Lansing Daniel I. Meara, Royal Oak Ted Miklas, MD, White Lake Susan L. Millett, Lansing Monika Mohan, Okemos David J. Mohlman, DO, Owosso Evan O. Mokwe, Detroit Jennifer L. Montague, Ann Arbor Adrienne Moore, Ann Arbor Ralph S. Mosca, MD, Ann Arbor Jason F. Moy, Haslett Thomas F. Moyad, Ann Arbor Michael I. Murphy, Lansing Samir Musleh, Detroit Kim Nguyen, Lansing Glen Ni, Ann Arbor David Niccolini, St Clair Shores Brian W. Nielsen, Woodhaven Nersi Nikakhtar, Ann Arbor Anita S. Ninan, East Lansing

Jasmin Ghuznavi, Detroit

Mark Girguis, Southfield

Alberto Garmo, W. Bloomfield

Jeanette Northerner, Trov Edward R. Oliver, Ann Arbor Michael I. Orlich, Ann Arbor Joseph M. Painter, MD. Hillsdale Kimberly L. Painter, Detroit Pratima Pandey, Farmington Hills Timothy J. Parcella, Warren Nikmil Parekh, Bloomfield Rajul B. Parikh, MD, Royal Oak Mitva Patel, Okemos Ojas Patel, Ann Arbor Christina Pelton, Ann Arbor Jennifer Perry, Detroit Heather Perry-Mills, Dearborn Christy A. Petroff, Ann Arbor Robert Pfeiffer, Royal Oak James P. Picott, Haslett Matthew Pillsbury, Ann Arbor Martin P. Powers, Ann Arbor Kara Rakoczy, Ferndale Nabila Rasool, Ann Arbor Jayne Rauwerda, Grand Rapids Pamela Reed, Okemos Randal Reinertson, Ann Arbor Kimberly S. Revnhout, Ann Arbor Brad Riley, Ann Arbor Brian Rill, Fenton Mark A. Ritter, Clinton Twp Sharon L. Roble, Lansing Yolanda Rosi, Ann Arbor Shila S. Roy, Bloomfield Hills Christina K. Rubio, East Lansing Iennie R. Sadlier, Okemos Rohit Sahai, Ann Arbor Jaswinder S. Sandhu, Detroit Ashok Sastry, Bloomfield Nathan Sauter, Ann Arbor Patricia L. Schafnitz, East Lansing Becky Schane, Ann Arbor Megan O. Schimpf, Ann Arbor Heidi Schrader, Ann Arbor Marlene B. Seltzer, MD, Troy Dawn M. Severson, St Clair Shores Susan E. Sharp, Ann Arbor

Andrew Shin, Okemos Malcolm Sickels, Ann Arbor Robert Sklar, MD, Troy Iill Slominski, East Lansing Gary A. Snapper, Belleville Antie Southwick, East Lansing Justin Strote, Ann Arbor Melissa D. Stuck, Harper Woods Michael I. Swaney, Royal Oak Jacqueline Tan, MD, Augusta Mehul Thakkar, Sterling Heights Steven R. Thiel. Haslett Iulia A. Trautschold, Grosse Pte Srini B Tridandapani, Ann Arbor Brad Trivax, Birmingham Henry T. Tsai, Detroit Shane Tsai, Ann Arbor Susan Tsai, Ann Arbor David S. Tung, Ann Arbor Heather Tuscany, Troy Matthew L. Ubell, Ann Arbor Andrej Urumov, Ann Arbor Omma G. Vaidya, East Lansing Anita S. Valanju, Southfield Robert A. Valice, Grosse Pte Shores Scott M. Vandenbelt, Detroit Nathan Van Houzen, East Lansing Aaron Van Wagnen, Holt Nick Vazquez, Ann Arbor Taher Vohra, Rochester Hills Katherine Vuckovich, Rochester Jenny Walker, Southfield Eric Warbasse, Bloomfield Hills Rachel S. Weiss, Ann Arbor James C. West, Ann Arbor John M. Whapham, Birmingham Christopher J. Whitty, Wyandotte Loren M. Wise, East Lansing Matthew Woods, Marshall Lori Wylie, Ann Arbor Alice Yang, Ann Arbor Neda Yousif, Ann Arbor Heather Zaluski, Portland Denise Zao, Ann Arbor

Mark Zeglis, Ann Arbor Aaron Zima, Ann Arbor Jay Zimmermann, Ann Arbor Ronald I. Zulkiewski, Belleville

Alan R. Mayer, MD

13,000th MSMS member

Alan R. Mayer, MD, a Sturgis emergency room physician, is the 13,000th member of MSMS. MSMS is one of the top two state societies nationally in membership growth, and Doctor Mayer brings MSMS to an all-time high, marking a steady climb over the last few years. MSMS would like to welcome Doctor Mayer, and introduce our 13,000th member!

Why MSMS? Doctor Mayer had been a part of a family practice group in Iron Mountain, MI, and recently has relocated to Centreville, MI. He now works as an independent physician in the emergency department of Sturgis Hospital, and decided to join MSMS because he wanted to be involved with a group of medical professionals.

Other affiliations? During his duration in Iron Mountain, Doctor Mayer was a member of the Dickinson County Medical Society and the American Academy of Family Physicians.

Why is membership in MSMS important? One reason Doctor Mayer joined MSMS was to keep in the mainstream about what's going on in Michigan concerning physicians. He hopes that membership will keep him abreast of the health care legislation in state and national government, trends, liabilities, etc.

Background. Doctor Mayer is originally from Ludington, MI. He received his undergraduate degree from Grand Valley State and his medical degree from the University of Chicago School of Medicine. For the past 10 years, Doctor Mayer and his family have lived in Iron Mountain, Mi.

Family. Doctor Mayer is married to Georgianna Mayer, and they have four children: Melissa, 12; Joanna, 9; Robby, 7; and Anthony, 4.

What is the latest book you've read? The Runaway Jury by John Grisham.

What are your hobbies? Doctor Mayer enjoys most outdoor activities, especially boating and fishing.

What is your favorite vacation spot? Doctor Mayer and his family enjoy traveling, and they visit Disney World, in Orlando, FL every year.

For more information of new membership in MSMS contact Jennifer Bates at (517) 336-5762, or e-mail her at jbates@msms.org.



Alan R. Mayer, MD; his son, Tony; and the family dogs.

Many members of MSMS are also very active in their respective specialty societies. The following is a list of the newly elected members of Michigan specialty societies. Please watch the people section of future Michigan Medicine issues for updates and additions.

MICHIGAN DERMATOLOGICAL SOCIETY

Board of Directors

Thomas A. Chapel, MD, President - Wayne County Thomas F. Anderson, MD, Secretary/Treasurer -Washtenaw County

Stephen W. Sturman, MD, President-Elect - Oakland

Michael T. Goldfarb, MD, Immediate-Past President -Wayne County

Thomas D. Harris, MD - Jackson County Andrew J. Mitchell, MD, - Wayne

MICHIGAN SOCIETY OF **PATHOLOGISTS**

Board of Trustees

Donald R. Peven, MD, Trustee - Wayne County Edward R. Powsner, MD, Trustee - Washtenaw County

MICHIGAN ALLERGY AND **ASTHMA SOCIETY**

Board of Directors

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Michael R. Simon, MD, Secretary - Wayne County Katherine W. Mauer, MD, Treasurer - Oakland County

Executive Committee Members

Steven M. Kreshover, MD, - Oakland County Alan Kwaselow, MD, Immediate Past President - Oakland County

Carol DeVore, MD, - Oakland County

MICHIGAN SOCIETY OF INTERNAL MEDICINE

Officers

Richard H. Wakulat, MD, President - Northern Michigan Medical Society

Remington Sprague, MD, President-Elect - Muskegon County

Laura Carravallah, MD, Secretary/Treasurer - Genesee

Ronald L. VanderLaan, MD, Past President - Kent County

MICHIGAN SOCIETY OF GENERAL SURGEONS

Board of Directors and Officers

Donald N. Reed, Jr., MD, President - Genesee County Jay D. Collins, MD, President-Elect - Medical Society of North Central Counties

Abdelkader Al Hawasli, MD, Secretary/Treasurer -Wayne County

James C. Lathrop, MD, Immediate Past President -Saginaw County

Robert G. Borchak, MD, - Wayne County

Richard T. Jefson, MD, - Kalamazoo Academy of Medi-

Anthony M. Kam, MD, - Ionia/Montcalm County

Charles A. Sanislow, MD, - Midland County

Arthur B. Yull, MD, - St. Clair County

Robert H. Hume, MD, - Kalamazoo Academy of Medicine

Donn M. Schroder, MD, - Wayne County

Donald C. Camp, MD, - Berrien County

Peter A. Duhamel, MD, - Oakland County

Larry R. Lloyd, MD, - Wayne County

Gary B. Talpos, MD, - Wayne County

MICHIGAN CHAPTER. AMERICAN COLLEGE OF SURGEONS

Executive Council

Larry Lloyd, MD, President-Elect - Wayne County Andrew Saxe, MD, Secretary - Wayne County Verne L. Hoshal, Jr., MD, Treasurer - Washtenaw County Krishna K. Sawhney, MD, Immediate Past-President -Wayne County

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EDUCATIONAL OPPORTUNITIES

Michigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

NOVEMBER

6-8, Advances in Psychiatry IX: 1997. Location: Towsley Center, University of Michigan, Ann Arbor, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, Phone (313) 736-1400. Approved for: 20 Category 1 credits.

- 7-9, Clinical Endocrinology for Primary Care Physicians. Location: Boca Raton Resort, Boca Raton, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.
- 12, 40th Annual Clinic Day, St. Joseph Mercy—Oakland, "Obesity & Sleep Apnea—A Multi-disciplinary Approach to Management." Location: St. Joseph Mercy—Oakland. Contact: Nancy Gawel (248) 858-3234. Approved for: 7.5 Category 1 credits.
- 12, Endocrinology Review Course. Location: The Fairlane Club. Dearborn, MI. Contact: Wayne State University Continuing Medical Education (313) 577-1180. Approved for: 5.5 Category 1 credits. Registration Fee: \$80
- 12-14, Ultrasound in Obstetrics and Gynecology. Location: Towsley Cen-

ter, University of Michigan, Ann Arbor, MI. Contact: Joyce Robertson. Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, Phone (313) 736-1400. Approved for: 22 Category 1 credits.

13-15, Mayo Clinic OB/GYN Clinical Reviews. Location: Mayo Foundation, Rochester, MN. Contact: Registrars, Mayo Foundation, 200 First St. S.W., Rochester, MN 55905. Phone: (800) 323-2688. Fax: (507) 284-0532. Approved for: 16 Category 1 credits, 16 AAFP Prescribed Hours, 16 ACOG Cognates. Registration Fee: \$350.

14-16, Neurology for the Non-Neurologist. Location: The Dolphin Resort, Orlando, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

15, Update in Office Cardiology. Location: Novi Hilton, Novi, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, Phone (313) 736-1400. Approved for: 4 Category 1 credits.

20-22, Managing Respiratory Diseases. Location: Hyatt Regency, Aruba. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

21-23, Arrhythmias: Interpretation, Diagnosis & Management. Location: The Regency Resort, Naples, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

21-23, Coronary Heart Disease Update. Location: Monte Carlo Hotel, Las Vegas, NV. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500. Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

21-23, Dermatology for the Non-Dermatologist. Location: Disneyland Pacific Hotel, Anaheim, CA. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

22, Hepatitis C Video Conference. Location: 1,000 local satellite sites through the Public Health Training Network. Contact: Hepatitis Foundation International, 30 Sunrise Terrace, Cedar Grove, NJ 07009. Phone: (800) 232-3299. Approved for: 2.5 Category 1 credits, 2.5 AAFP Prescribed Hours. Registration Fee: \$25.

22, Update in Office Cardiology. Location: Novi Hilton, Novi, MI. Contact: Joyce Robertson, Towsley Center of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, University of Michigan Medical School, P.O. Box 1157, Ann Arbor, MI 48106-1157, Phone (313) 736-1400. Approved for: 4 Category 1 credits.

DECEMBER

4-6, Clinical Endocrinology for Primary Care Physicians. Location: Hyatt Regency, Grand Cayman, BWI. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

5-7, Managing Respiratory Diseases. Location: Casa Marina Resort, Key West, FL. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

5-7, Dermatology for the Non-Dermatologist. Location: Marriott Marquis, New York, NY. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

11-13, Coronary Heart Disease Update. Location: Atlantis Paradise Resort, Nassau, Bahamas. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

12-14, Arrhythmias: Interpretation, Diagnosis & Management. Location: Monte Carlo Hotel, Las Vegas, NV. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

12-14, Neurology for the Non-Neurologist. Location: Camelback Inn, Scottsdale, AZ. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

"Ask our Lawyer" continued from page 8

Representative Start and Kildee would amend the ERISA law to permit compensatory, consequential and punitive damage for injuries caused by "cost containment techniques" and "any utilization review directed at cost containment." Another measure has been introduced by Representative Norwood. This would address the problem by removing ERISA preemption from state law claims, thereby allowing the plaintiff to seek the remedy available under state law.

The author is senior partner with Kerr, Russell & Weber, Detroit.



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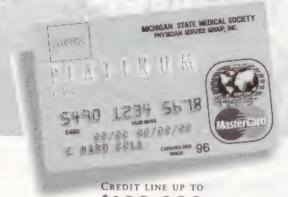
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MSMS

November

- 5-7, MSMS Annual Scientific Meeting. Location: Hyatt Regency, Dearborn. Contact: James Tarrant at MSMS at (517) 336-7591.
- 12, MSMS/MPMLC Risk Management Seminar. "Physician Criminal Exposure." Location: Holiday Inn Gateway Centre, Flint. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 13, MSMS/MPMLC Closed Claim Review. Location: Fetzer Center, Kalamazoo, Contact: Darla Brandon, (517) 336-5769.
- 17, MSMS/MPMLC Risk Management Seminar. "Anatomy of a Lawsuit." Location: Double Tree Hotel, Novi. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 18, MSMS/MPMLC Seminar. "Negotiating Safe Passage in a Changing Healthcare Environment." Location: MSU Management Education Center, Troy. Contact: Darla Brandon, (517) 336-5769.
- 18, MSMS Internet Training Seminar. Location: Battle Creek. Contact: Jody Jodway at MSMS at (517) 336-5604.
- 19, MSMS Board of Directors. Location: MSMS Headquarters, East Lansing. Contact: Irene Frost, (517) 336-5734.
- 20, MSMS/MPMLC Risk Management Seminar. "Emergency Ser-

- vices." Location: Holiday Inn Airport, Kalamazoo. Contact: Liz Treanor, (810) 748-0465, ext. 288.
- 20, MSMS/MPMLC Closed Claim Review. Location: St. Joseph Hospital East, Mt. Clemens. Contact: Darla Brandon, (517) 336-5769.
- 21, MSMS Internet Training Seminar. Location: Roscommon. Contact: Jody Jodway at MSMS at (517) 336-5604.
- 22, MSMS Internet Training Seminar. Location: Flint. Contact: Jody Jodway at MSMS at (517) 336-5604.
- 29, MSMS Internet Training Seminar. Location: Lansing. Contact: Jody Jodway at MSMS at (517) 336-5604.

December

- 3, 4, MSMS/MPMLC Risk Management Seminar. "Pathology." Location: Holiday Inn North Campus, Ann Arbor, MI. Contact: Darla Brandon, (517) 336-5769
- 4, MSMS Internet Training Seminar. Location: Grand Rapids. Contact: Jody Jodway at MSMS at (517) 336-5604.
- 11, MSMS Internet Training Seminar. Location: Auburn Hills. Contact: Jody Jodway at MSMS at (517) 336-5604.

AMA

December

4-10, 1997 AMA Interim Meeting. Location: Wyndham Anatole Hotel, Dallas, TX. Contact: Judy Marr at MSMS at (517) 336-5745.

SPECIALTY SOCIETIES

November

- 4, Michigan Department of Community Health Regional Immunization Conference. Location: Ypsilanti. Contact: Rosemary Franklin, (517) 355-9485.
- 7-9, Michigan Association of Medical Examiners Annual Meeting. Contact: Melissa Wiegand at MSMS at (517) 336-7586.
- 21, Michigan Committee for Prevention of Child Abuse. Location: MSMS headquarters. Contact: Jean Smith at MSMS at (517) 336-5604.

"Truths and myths" continued from page 43

ior. For example, patients must agree not to get narcotics from other doctors. Also, we accept no excuses for refilling early, and we only adjust medications at the time that the next prescription is due. Patients need to be advised to discuss any changes in dosing directly with the physician and not to undertake changes on their own.

In our practice, we have one person assigned to filling narcotic prescriptions and maintaining meticulous records on dispensation. Office staff also should log all telephone calls, even those situations where they do not give a prescription. That way, if the patient is establishing a pattern of negative behavior "calling in early, requesting extra medications, etc." the chart will reveal this, and the doctor can discuss this behavior with the patient at the next appointment. On occasion, we have to ask patients to come in before a scheduled appointment to discuss problems that arise as a consequence of their conduct.

Adhering to these standards in a structured environment to improve pain control can reduce the potential for abuse and criticism. Class two and three scheduled narcotics then can be given safely in selected patients to provide a level of relief that otherwise may not be obtained.

Mark Gostine, MD, is partner and co-founder of Michigan Pain Consultants, PC (MPC), a multidisciplinary pain management practice specializing in the diagnosis, treatment and relief of chronic and acute pain syndromes.

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President's Perspective continued from page 64 care purchasers, the media and consumer groups.

10. MSMS launched its Institute for Education and Leadership

This new coordinated center will focus on what historically has been a center of excellence for our medical society: education. In addition to CME, it will deliver a comprehensive schedule of non-clinical programs on the business of medicine, as well as training and certification for medical office staff.

MSMS has accomplished these things and more, and continues to move us all forward. There are so many more things I could add to the list; such as strong grassroots political action on the part of our members, which will be more important than ever as we approach an unusual election year.

We have done all this and more without a dues increase for eight years, thanks to extraordinary financial management, and growing non-dues income. We are in very good shape as we look to next year, and I believe our dues investments are the best ones we can make as physicians today.

Doctor Duhamel is MSMS president.

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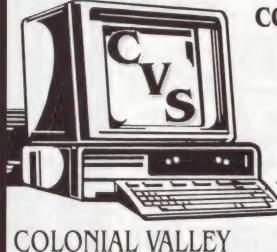
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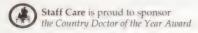
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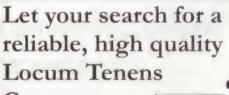
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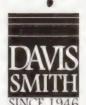


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Centers of excellence

Top 10 MSMS achievements insure better member service and strong advocacy

By Peter A. Duhamel, MD

Good news—MSMS has welcomed its 13,000th member! That's quite a milestone, especially these days when medical society membership nationwide is suffering.

I am not surprised by our climbing numbers, though, and I'll tell you why: MSMS has continued to be relevant and essential to its members. And we've done it by anticipating developments, and being more than ready when change arrives on the scene. We're strong when we use our collective strength and smarts to advocate for what is right for the practice of medicine and for our patients.

It occurs to me that this has been an especially productive and effective year. These are my picks for this year's top ten achievements:

1. Michigan Medical Advantage was Launched

This MSMS and MPMLC sponsored management services organization assists physicians in negotiating managed care contracts and provides information systems, utilization and quality management, and other services physicians need to deliver high quality, cost-effective care under those contracts.

2. MSMS Approved a Single **Credentialing Form**

The MSMS Board approved a single credentialing form endorsed by the Michigan Association of Health Plans. Doctors will need to complete the single form only once, greatly reducing the time and paperwork that used to be involved in the credentialing process. The MSMS Professional Credentials Verification Service will help to further streamline the process by urging all Michigan health plans and HMOs to use its services.

3. MSMS Won Passage of the Patient Bill of Rights

This legislation limits the time period in which insurance companies can deny coverage for a preexisting condition, and requires plans to renew policies for these patients, provide for a timely and accessible grievance process and to clearly inform patients of plan policies. MSMS supports proposed legislation which will further those protections.

4. MSMS task force formed to review Law Regulating BCBSM

MSMS formed a task force to review PA 350, the legislation regulating the insurer, and opened talks with BCBSM to discuss their intentions. MSMS will to continue its work to maintain due process for physician appeals to the insurer.

5. MSMS Released Second Annual Evaluation of Michigan Health Plans

MSMS conducted and released its second report on important financial data and other pertinent information to help physicians make informed decisions regarding participation with health plans in the state.

6. MSMS Focuses on End of Life Care and Bioethics

MSMS convened forums to explore all facets of the issues regarding the end of life, including physician assisted suicide, pain management and hospice. A new Committee of Hospice Medical Directors was formed, and continues to work to educate doctors and their patients about hospice services. On September 26-28 MSMS presented its first Annual International Mackinac Island Conference on Bioethics.

7. MSMS Continued its Press for Fair Reimbursement

MSMS' Reimbursement Ombudsman averaged 100 phone inquiries per month, or 1200 calls in the past year which resulted in the recovery of thousands of dollars for Michigan physicians. MSMS also has filed a legal brief to support consistent and reasonable fees be paid to physicians by no-fault carriers, and is active in facilitating physician involvement with local business coalitions and purchasers in the communities where physicians practice.

8. A Full Calendar of Risk Management Programming Was Offered

MSMS and MPMLC presented a comprehensive calendar of quality risk management programming for physicians and office staff, including closed claim reviews, specialty-specific programs, in-office consultations and conferences.

9. MSMS Released Reports on Practice Characteristics and Health Status

The MSMS Practice Characteristics survey results detailed how Michigan physicians have responded to changing incentives, and new rules and criteria. It also depicts emerging trends, and monitors changes in the medical marketplace. MSMS also compiled a Review of the Health Status of Michigan's Citizens as a tool for discussion with legislators, community leaders, health

continued on page 57



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Edgar P. Balcueva, MD Saginaw



Ali Esfahani, MD Flim



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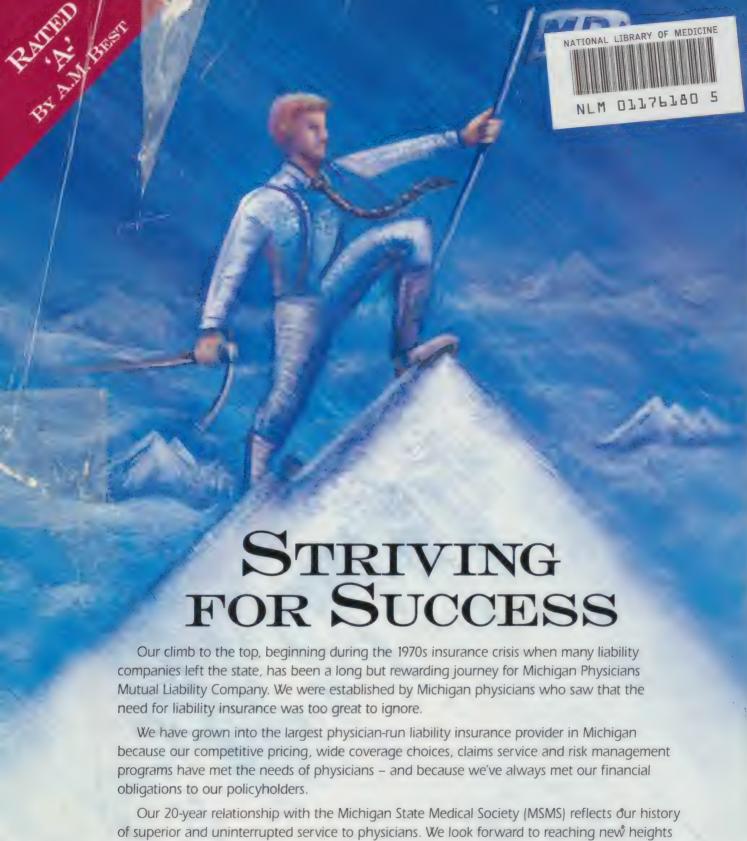
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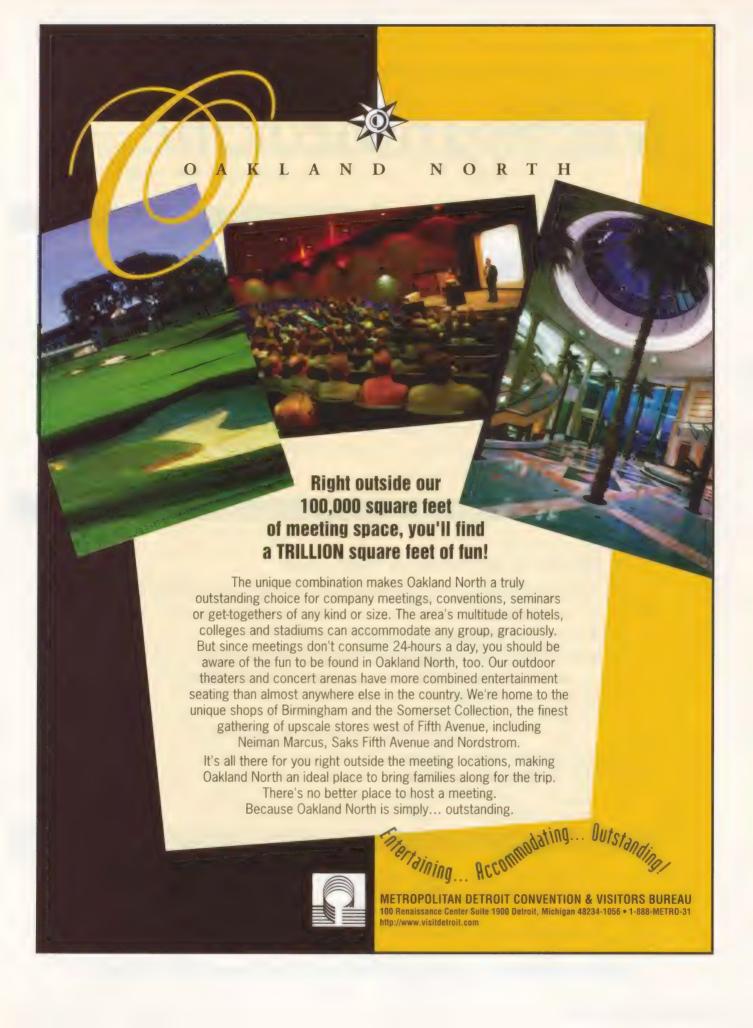
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MichiganMedicine

COVER STORY



Hospital Mergers Coping with change in the health care marketplace

24

This month's cover story begins a series of articles which will appear in Michigan Medicine over the coming months exploring the impact of the many types of mergers in physicians' lives. This first article spotlights the merger of hospitals, especially the Butterworth/Blodgett merger in Grand Rapids. With each offering we will provide guidance for MSMS members, to help them survive and thrive in the swirl of change. MSMS believes that physicians are the key in the delivery of medical care, and that they will emerge the centerpiece in the jugsaw puzzle of change.

By Karen Bouffard

FEATURES

MSMS ISSUES BRIEF

ERISA and its impact on health care

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MSMS has taken steps at all levels to institute changes in the application of ERISA to health care.

SPECIAL FEATURE

A force for improving health care Blue Cross Blue Shield of Michigan Foundation

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The Blue Cross Blue Shield of Michigan Foundation (BCBSM) is dedicated to improving the health of Michigan citizens through research and service.

By Ira Strumwasser, PhD, and Willard S. Stawski, MD

PRACTICE MANAGEMENT

ICD-9 Code Changes

18

The additions, revisions and deletions in the diagnosis ICD-9 codes. They were effective October 1, 1997 and likely will be required by payers, including Medicare, as of January 1, 1998.

By Joyce A. Nurenberg

PHYSICIAN PROFILE

Marigowda Nagaraju, MD Making a difference in Flint

20

Despite the financial attractions of a career in medicine, physicians need commitment to helping others to sustain them through the heavy costs and pressures of medical training and building a practice.

By Ralph D. Ward

December 1997 Volume 96, Number 12

MSMS Internet Website Address: http://www.msms.org/

MSMS E-mail Address: msms@msms.org



EATURES

MEDICAL ECONOMICS

The 'U' word

Physicians and unions—What's the possibility?

This article responds to the current upsurge of interest in unions by physicians in certain parts of the country. The heightened interest in unions comes at a time when physicians feel increasingly powerless to respond to the tremendous leverage exerted by health plans.

PHYSICIAN PROFILE

The Clarksons-Jack, MD and Tess, MD

36

Doctors Tess and Jack Clarkson of Ovid extend their medical partnership into a hobby/sideline that keeps them busy—and successful—in the world of music.

By Ralph D. Ward

PHYSICIAN SPOTLIGHT

Rural family practice: The dream and the reality

38

40

The many roles of a rural physician help to see the big picture of health care today. By Craig K. Matheson, DO

CASE STUDY

MSMS joins AMA, national specialties in fourth case study: SSPNs offer specialty physicians market opportunities

Just a few years ago, it was suggested that specialists "re-tool" themselves by becoming primary care physicians. Today, specialty physicians are surviving and in many cases thriving under managed care by reconfiguring their contracting strategies.

By Thomas M. Gorey, JD and Nancy K. Bannon, JD

BIOETHICS OVERVIEW

Bioethics conference tackles tough subjects

44

Evaluations were enthusiastic from more than 100 participants at the first MSMS Mackinac Island Conference on Bioethics held at Grand Hotel September 26-28 where issues included physician assisted suicide and genetic technology.

By David K. Fox

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"I get the sense of a rededicated effort at MSMS to help physicians."

Michael H. VanderKolk, MD

Helpful tools for physicians to counsel patients about smoking cessation

At least 70 percent of all adult smokers want to quit their addiction to tobacco. Research shows that the best person to advise smoking patients to quit smoking is the physician. Only half of the smokers who see a doctor have ever been urged to quit, even though smoking is the single greatest preventable cause of illness and premature death in the United States. Patients' responses show that just a bit of encouragement from a physician can make a real difference in changing their attitudes about quitting.

Physicians can play a vital role in reducing the number of smoking-related deaths by helping patients stop smoking. By the simple act of providing smoking cessation advice, your members will be participating in a major and far-reaching public health initiative.

The reason some physicians give for not counseling patients to quit is their lack of resources to assist these patients.

The ALA can assist you with the resources necessary to help patients stop smoking. The ALA has 99 local constituents/affiliates throughout the country. Each of these can be easily accessed by having patients who smoke call 1-800-LUNG-USA. Please let your patients know about this important resource.

Thomas P. Houston, MD

American Medical Association

Change in health certificate still urges HIV counseling for marriage license

Under Michigan's Premarital Law, an individual applying for a marriage license must present to the County Clerk, a Health Certificate for Marriage License indicating that the applicant has been counseled and offered testing for sexually transmitted diseases and HIV infection or a written statement citing that the counseling requirements violate the personal religious beliefs of

the applicant. The law was implemented in 1988. The Department has indicated that the certificate is valid for only 60 days, beginning on the date counseling is completed. On occasion, the 60-day limit has had to be waived to accommodate unusual circumstances.

Effective immediately, we will no longer require that this certificate be valid for only sixty days. Rather, we are recommending that counseling be done 60-90 days before applying for the license and that discretion be used to accommodate the schedules of persons requesting counseling and applying for a marriage license. The Health Certificate for Marriage License (V-90) is being revised to reflect this change. Until it is issued, the old forms should be used.

We believe that the law still provides an important opportunity for persons who intend to marry to learn about their risks for sexually transmitted diseases and HIV infection. We would urge all persons eligible under the law to provide this counseling and to offer testing to encourage that this counseling be done in a timely manner before marriage.

James K. Haveman, Jr.

Department of Community Health

Kudos to MSMS reimbursement ombudsman!

I am very impressed with the work that Ms. Joyce Nurenberg, MSMS reimbursement ombudsman, has been doing with regard to reimbursement problems. We have had increasing difficulty with Blue Care, specifically, and other payers. She has been very helpful and I get the sense of a rededicated effort at MSMS to help physicians.

I appreciate that and wanted to make you aware that someone has noticed.

Michael H. VanderKolk, MD

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Tailgating for Charity

On October 25, 1997, prior to the Michigan State vs. University of Michigan football game, MSMS hosted a "Tailgate for Charity," celebrating "Doctors and Their Families Make a Difference in Michigan." The event was well attended—despite the chilly weather—with more than 200 participants. The \$3,500 raised will support the MSMS Foundation (formerly the Health Education Foundation), which funds community health promotion projects statewide.

In the October 12, 1997 issue of USA Weekend Magazinereaching 20.4 million households-MSMS' and the MSMS Alliance's "Doctors and **Their Families** Make a Difference" campaign was recognized as a model statewide effort!



MSMS President, Peter A. Duhamel, MD, (left) and Alliance President, Blanche Mindlin (right) beside the MSMS banner for "Doctors and Their Families Make a Difference in Michigan."



(from left to right) MSMS President-Elect, Cathy O. Blight, MD; Samuel R. Dismond, MD; Alliance member Jan Dismond, RN; Alliance President Blanche Mindlin and MSMS Board member Donald B. Muenk, MD, enjoy lunch during the tailgate event.



MSMS President Peter A. Duhamel, MD (right); Alliance President Blanche Mindlin (left) and MSU Chair of the Department of Radiology E. J. Potchen, MD (center), are recognized on the Spartan Stadium field during half time. They served as representatives for all doctors, their families and medical students who make a difference in Michigan.



(from left to right) MSMS President Peter A. Duhamel, MD; MSMS member Marsha M. Madigan, MD; Alliance member Lois Duhamel; MSMS member Alan M. Mindlin, MD; Alliance President Blanche Mindlin; MSMS Executive Director William E. Madigan and MSMS President-elect Cathy O. Blight, MD, gather at the tailgate tent prior to leaving for the big game.

More than 100 physicians, their spouses and their children were recognized for their volunteer work in the October issue of Michigan Medicine.

Medical directors' responsibility for medical necessity decisions

By Richard D. Weber, JD MSMS Legal Counsel



Question: Are physicians who work as medical directors for insurance companies or managed care organizations subject to discipline by the State Board of Medicine if they make inappropriate medical necessity decisions? Shouldn't these medical directors who are not practicing physicians, and are making medical decisions that affect patients, be held to the same standards as practicing physicians? Can you comment on the law in this area?

Answer: Absent a physician-patient relationship, a physician may not be sued by the patient for medical malpractice in Michigan, Recent legislation enacted in other states and a bill pending in Michigan would, however, subject managed care organizations, their physicians and agents to liability for negligent decisions that adversely affect patients' health. This was the subject of last month's Ask Our Lawyer column.

The issue presented in your question relates to the authority of the State Board of Medicine to discipline a physician, even though that physician was not practicing medicine in the traditional sense and had no physician-patient relationship. There is no law on this subject in the State of Michigan.

An appeals court in Arizona, however, recently has addressed this issue. A physician licensed to practice medicine in Arizona and employed as a medical director of Blue Cross and Blue Shield of Arizona denied pre-certification for a patient's gall bladder surgery after finding that it was not medically necessary. The decision contradicted the advice of the patient's physician, who performed the surgery anyway. Blue Cross subsequently paid the claim because the post-surgical report substantiated a need for the surgery. The patient's physician filed a complaint with the Arizona Board of Medicine against the physician medical director, alleging unprofessional conduct and medical incom-

The case ended up in the Arizona Court of Appeals on the issue of whether the Board of Medicine has jurisdiction to regulate the conduct of a licensed physician whose position as medical director for a managed care company requires him to render decisions that potentially affect patients' medical care.

The court found that the Board of Medicine has jurisdiction. Contrary to the argument of the physician/medical director, the court further held that the physician was not a provider of insurance, but rather was an employee who makes medical decisions for his employer concerning whether surgeries and other non-experimental procedures are medically necessary. The court found that such decisions are not insurance decisions because they require a determination as to whether the procedure is appropriate for the symptoms and diagnosis of the condition, whether it is to be provided for the diagnosis, care and treatment and whether it is in accordance with standards of good medical practice in Arizona. Following the ruling, Blue Cross stated it would appeal to the state supreme

This decision by the Arizona appellate court could have far-reaching implications. The decision should make medical boards of other states, including Michigan, more confident in taking action against physicians who work for insurance companies or managed care organizations in making inappropriate decisions about patient care.

Do you have a question for MSMS legal counsel? Please call, write, fax or e-mail Judith Marr, Editor, at P.O. Box 950, East Lansing, MI 48826-0950; (517) 336-5744; fax (517) 336-5797; or imarr@msms.org.

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ISSUES BRIEF

This issues brief is the first in an important new series of background pieces prepared for MSMS members. Look for future briefs—PA 350 in January—in coming issues of *Michigan Medicine*. The briefs also can be found on the MSMS Internet homepage for downloading at http://www.msms.org/

ERISA and its impact on health care

n 1974, the Employee Retirement Income Security Act (ERISA) was enacted to protect employee pension and benefit packages. Since then the structure of health care delivery has changed significantly, exposing a loophole in the original wording of the legislation. As a result, unlike physicians and hospitals, many managed care organizations (MCOs) cannot be held liable for any of the medical decisions they make. The law makes the MCOs untouchable, and thereby unfairly directs parties injured by the decisions of the MCO to seek damages from the physician or the hospital. In short, patients may suffer, physicians and hospitals may be unfairly penalized and MCOs continue to escape accountability for their actions.

MSMS Action

MSMS has taken steps at all levels to institute changes in the application of ERISA to health care. At the federal level, MSMS has informed the Michigan lawmakers of how the current ERISA law is detrimental to physicians, hospitals, and constituents covered by ERISA-regulated health plans.

MSMS also has been instrumental in attempts to introduce legislation at the state level. State Representative Laura Baird (D-Okemos) has recently introduced a H.B. 5221 in the near future that will raise the standard of care for ERISA plans to be commensurate with non-ERISA plans. The legislation also will include language that precludes managed care organizations from including physician indemnification clauses in their contracts, thereby eliminating the ability of the managed care organization to shift liability to the physician.

MSMS also has been active in the judicial branch in an attempt to overrule the policies set forth by ERISA. In the case BPS Clinical Labs v. Blue Cross and Blue Shield, BCBS claimed

they were exempt from statutory and common law under the provisions of ERISA. Both parties filed Applications for Leave to Appeal to the Michigan Supreme Court. The Court of Appeals, on remand, held that ERISA does not preempt state law claims, including breach of contract and torts, along with violations of Act 350, the Prudent Purchaser Act and the Michigan Antitrust Reform Act. MSMS filed an amicus brief opposing BCBSM's application on January 20, 1997. A supplemental brief citing new supportive authority was filed by MSMS in the summer of 1997.

ERISA-Why reform is needed

The Employee Retirement Income Security Act of 1974 (ERISA) was a timely piece of legislation originally conceived to protect existing employee pensions and encourage employers to create new benefit plans for their workers. The law established universal federal guidelines to protect workers and their benefits. Ironically, in the wake of significant changes in the delivery of healthcare, ERISA has become the means to deny benefits to the very people it was originally designed to protect.

What is ERISA?

Originally ERISA was enacted to protect employer-sponsored pension and benefit plans. At the time, legislation was needed to address widespread cases of workers losing their pension benefits due to plant closings or poor financial management. ERISA set minimum requirements for employer-sponsored pension funds aimed at accomplishing two directives. First, workers that have invested in a private pension fund are guaranteed to receive their benefits. Second, it eases any state regulations that may encumber the formation of an employer-sponsored benefit package.



The ERISA Preemption Clause

ERISA has been most closely associated with its efforts to protect pensions. However, the impact ERISA has had on stimulating the formation of new private employer-sponsored benefit packages has been substantial. Contained within ERISA is language for a federal preemption of state laws pertaining to insurance regulations and premium taxes. For example, the state may regulate the employersponsored health plan if the coverage is purchased from an insurance company; however if the plan is self-insured, state laws are circumvented in favor of ERISA.

Implications

ERISA was established at a time when selfinsured businesses were few in number. Today, over two-thirds of all businesses are self-insured. The growth of self-insured employers can be attributed to ERISA; however, this growth also has accentuated shortcomings of the law. Instead of complying with the regulations of the individual states, self-insured employers need only adhere to standards outlined by ERISA. Plans governed by ERISA are not affected by state laws that mandate minimum care standards for diseases such as alcoholism and AIDS, or preventative care such as mammograms and blood screenings.

Health care delivery has changed substantially since the inception of ERISA. Health plans have tended to centralize decision-making, and have enacted other policies aimed at containing costs. As many self-insured employers seek to find more cost efficient forms of health care for their employees, yet another shortcoming of ERISA is exposed. The preemption clause allows health plans of self-insured programs to be exempt from liability regarding the medical decisions they make. For example, if an ERISA regulated plan denies a child a blood test, and the child subsequently dies from leukemia, the amount recoverable as outlined by ERISA would be equal only to the amount of the denied procedure. In this case, it would represent approximately \$130; conversely, the doctor or hospital that may have requested the test initially can be sued for both compensatory damages and further damages for pain and suffering.

Changes are Needed

ERISA has been successful in achieving its goal of protecting the pensions of workers. However, the preemption clause has proved to be detrimental to attempts by states to reform health care and is an impediment to doctors trying to practice good medicine. ERISA was intended to protect employees. Unfortunately they are now victims of cost containment policies that are protected by ERISA. The original proponents of ERISA could not have foreseen the widespread changes that have taken place in health care in recent years; however, the need for a reevaluation of ERISA is necessary in order to hold the managed care companies accountable for their decisions and to eliminate the liability loophole.

Currently, there is legislation pending at the federal level to amend the preemption clause contained in ERISA.

Federal Legislation

- Senate Bill 1136- The Employee Health Insurance Accountability Act of 1997, sponsored by Senator Durbin (D-IL) seeks to return the area of medical malpractice to the jurisdiction of the states by removing the ERISA preemption. The four stated goals of the bill are to increase patient protection, achieve an equitable assignment of liability, give members of employer-sponsored health plans legal redress and restore accountability to employer-sponsored health plans.
- House Resolution 1415- The Patient Access to Responsible Care Act of 1997 introduced by Representative Norwood (R-GA) contains language outlining the removal of the ERISA preemption and allowing employersponsored health plans to be within the jurisdiction of State insurance laws and regulation.
- House Resolution 1789- The Managed Care Accountability Act of 1997 introduced by Representative Stark (D-CA), Representative Kildee (D-MI) and Representative Lowey (D-NY) contains provisions that make managed



care companies liable for their medical decisions. The bill stipulates that any cost containment policy, or utilization review directed at cost containment that restricts providers from using their full discretion when treating patients, may be held liable for their policies.

Conclusion

ERISA has served to protect pension holders effectively. However, the consequences that have arisen from the preemption clause have been severe. In that context, ERISA should be amended, keeping the part that works and adjusting the portions that are no longer feasible. Providers should not be held accountable for policies that they may not support, or have control over. Patient care will continue to suffer as well: currently the law allows that economic reasons can overrule the best interests of the patient.

The goal of ERISA reform is not to impose strict guidelines that the health plans must follow; rather, reforms have been aimed at attaining an equal level of accountability among ERISA regulated plans, non-ERISA regulated plans, providers and hospitals. As long as ERISA remains unchanged, horror stories of the unfortunate results of HMOs denving mammograms, blood screenings and other necessary treatments will persist. Congress must take the steps required to implement these changes, and protect those covered by ERISA regulated plans.

For Further Information

If you would like any further information regarding ERISA, or if you have any questions regarding the pending legislation, please contact Kevin A. Kelly, MSMS Managing Director at (517) 336-5742 or e-mail him at kkelly@msms.org. You also may contact Colin J. Ford, MSMS Executive Office Intern at (517) 336-5708 or e-mail him at colin@allstaff.msms.org.

MSMS Highlights Other Sources of Information for You!

ERISA's preemption clause extends well beyond the interests of the Michigan State Medical Society. Medical societies in all states are affected by the same challenges as Michigan. Likewise, state governments that are trying to make strides in improving the delivery of health care in their states are severely impeded by ERISA, making meaningful change more difficult to impose. The following sources can give further perspective on all of the implications of ERISA.

American Journal of Public Health, Liability for Managed Care Decisions: The Employee Retirement Income Security Act (ERISA) and the Uneven Playing Field. By Wendy K. Mariner, June 1996.

Group Practice Journal, Liability for Medical Decision Making: Will Congress Decide Who's Responsible? By Thomas E. Giles and Mary Kuffner, September 1997.

Journal of Health and Hospital Law, ERISA and Managed Care: The Law Abhors a Vacuum. By Margaret Farrell, Volume 29, Number 5.

Michigan Department of Public Health, Health Policy Update, February 1, 1995.

Michigan Medicine, Managed Care Tort Liability, By Richard D. Weber, JD, Volume 96, Number 10.

A force for improving health care

Blue Cross Blue Shield of Michigan Foundation

By Ira Strumwasser, PhD, and Willard S. Stawski, MD

The Blue Cross Blue Shield of Michigan Foundation (BCBSM) is dedicated to improving the health of Michigan citizens through research and service. The Foundation was created by BCBSM in 1980 with \$800,000 in seed money. Three years later, Michigan physicians endowed the Foundation with more than \$19.2 million in incentive funds from a BCBSM cost-containment program. Thanks to this endowment, the Foundation expanded the focus and breadth of its grantmaking. Since then, the Foundation's assets have grown through investment income to approximately \$40 million.

Last year, the Foundation had available more than \$1.2 million in grants to Michigan-based researchers and non-profit organizations. The Foundation was created by BCBSM in 1980. As the philanthropic affiliate of BCBSM, the Foundation is governed by a separate board of directors.

Improving health care

The BCBSM Foundation is building roads for researcher and non-profit community organizations to make a difference in the health of Michigan residents. The majority of the Foundation's grantmaking is for health and medical research. The flagship of the Foundation's research programs, the "Investigator Initiated Research Program," produces useful information for physicians, administrators and policy-makers designed to enhance access to appropriate care, improve quality and contain the costs of care.

The Foundation also promotes in-depth research on specific health topics through the "Request for Proposal Program." In 1996 and 1997, the Foundation developed two "Request for Proposal" projects: The Women's Health and The African American Health Research Initiatives.

The "Student Award Program" creates opportunities for medical and doctoral students at Michigan universities to gain research experience while completing their education. Through our "Matching Initiative," the Foundation supports professional conferences and seminars. This year, the Foundation sponsored the MSMS First Annual Conference on Bioethics.

Community grants

The Foundation creates opportunities for non-profit health service organizations through fund-

ing collaborations and direct program support. Our community grantmaking helps organizations build the resources necessary to bring local health initiatives to life.

Investigator initiated research

The "Investigator Initiated Research Program" is available to health care researchers interested in finding ways to improve health care in Michigan. Projects address health care costs, quality and access to services. This program supports research on health service organization and delivery, including managed care, new methods and approaches to providing access to appropriate care, quality of care, utilization review and cost-containment, clinical protocols and practice guidelines development and evaluation.

Matching initiative program

The "Matching Initiative Program" supports a variety of innovative health service projects and fosters collaboration among foundations and other funding organizations. This funding helps non-profit service organizations expand their capabilities to establish or enhance their health delivery programs.

"Our community grantmaking helps organizations build the resources necessary to bring local health initiatives to life."

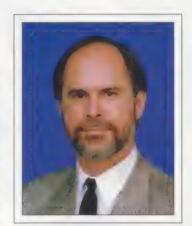
The following MSMS members received grants from the Blue Cross Blue Shield of Michigan Foundation in 1997:

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Steven J. Lavine, MD Kathleen M. Longo, MD Richard D. Nichols, MD Jeffrey A. Sanfield, MD

Physician investigator research

Physicians have an intimate perspective on patient care and are often the first to identify health care practice concerns. The "Physician Investigator Research Award"



Ira Strumwasser, PhD

provides seed money to physicians to explore the merits of a particular research idea for further study. We offer grants of up to \$10,000 for projects that include pilot studies, feasibility studies or small research studies in clinical or health services research.

Proposal development award

Many innovative ideas for improving health care delivery are born in community service organizations. However, because these organizations are usually lean operations, both in staff and funding, many valuable ideas never become reality. The "Proposal Development Award" helps community non-profit organizations secure funding to bring these ideas to life. Proposal development can require specialized assistance, which is often beyond the financial reach of nonprofits. This \$2,500 grant helps pay for technical assistance, freelance proposal writers and related production costs. With this assistance, community non-profit organizations can develop high quality, effective proposals that improve the likelihood of capturing the attention of funders and bring resources to our communities.

Excellence in research

Michigan has been a long-time leading site of health care research. For more than 15 years



Willard S. Stawski, MD

the Foundation has supported this research through our grantmaking. In 1996, we continued this commitment to supporting the best in research by introducing our annual "Excellence in Research Award."

This award honors researchers who make significant contribution to improving health care in Michigan. Separate awards honor physician researchers and individuals with non-medical research degrees.

Grant proposal evaluation

Grant proposals are reviewed by staff to determine if they meet program guidelines and objectives. Proposals are sent to members of our Grants Advisory Panel for external review. Based upon Grant Advisory Panel and staff reviews, funding recommendations are presented to the BCBSM Foundation board of directors for consideration. For additional information about any of the Foundation's grant programs, please contact BCBSM Foundation 600 Lafayette East-#B243, Detroit, MI, 48226; phone (313) 225-8706.

Ira Strumwasser, PhD, is the executive director and CEO of the BCBSM Foundation. Doctor Stawski is a member of both the BCBSM Board of Directors, and MSMS.

Physicians have an intimate perspective on patient care and are often the first to identify health care practice concerns.

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ICD-9 Code Changes

By Joyce A. Nurenberg

The following are the additions, revisions and deletions in the diagnosis ICD-9 codes. They were effective October 1, 1997 and likely will be required by payers, including Medicare, as of January 1, 1998.

New Diagnostic Codes

007.4 Other protozoal intestinal diseases, cryptosporidiosis

031.2 Disease due to disseminated mycobacterium avium-intracellulare complex

038.10 Staphylococcal septicemia, unspecified

038.11 Staphylococcus aureus septicemia

038.19 Other staphylococcal septicemia

275.40 Unspecified disorder of calcium metabolism

275.41 Hypocalcemia

275.42 Hypercalcemia

275.49 Other disorder of calcium metabolism

438.0 Late effect of cerebrovascular disease, cognitive deficits

438.10 Late effect of cerebrovascular disease, speech and language deficits, unspeci-

438.11 Late effect of cerebrovascular disease, speech and language deficits, aphasia

438.12 Late effect of cerebrovascular disease, speech and language deficits, dyspha-

438.19 Late effect of cerebrovascular disease, other speech and language deficits

438.20 Late effect of cerebrovascular disease, hemiplegia affecting unspecified side

438.21 Late effect of cerebrovascular disease, hemiplegia affecting dominant side

438.22 Late effect of cerebrovascular disease, hemiplegia affecting nondominant side

438.30 Late effect of cerebrovascular disease. monoplegia of upper limb affecting unspecified side

438.31 Late effect of cerebrovascular disease, monoplegia of upper limb affecting dominant side

438.32 Late effect of cerebrovascular disease, monoplegia of upper limb affecting nondominant side

438.40 Late effect of cerebrovascular disease, monoplegia of lower limb affecting unspecified side

438.41 Late effect of cerebrovascular disease, monoplegia of lower limb affecting dominant side

438.42 Late effect of cerebrovascular disease, monoplegia of lower limb affecting nondominant side

438.50 Late effect of cerebrovascular disease, other paralytic syndrome affecting unspecified side

438.51 Late effect of cerebrovascular disease, other paralytic syndrome affecting dominant side

438.52 Late effect of cerebrovascular disease. other paralytic syndrome affecting nondominant side

438.81 Other late effect of cerebrovascular disease, apraxia

438.82 Other late effect of cerebrovascular disease, dysphagia

438.89 Other late effects of cerebrovascular

438.9 Unspecified late effects of cerebrovascular disease

458.8 Other specified hypotension

474.00 Chronic tonsillitis

474.01 Chronic adenoiditis

474.02 Chronic tonsillitis and adenoiditis

482.84 Legionnaires' disease

Allergic bronchopulmonary aspergillosis

655.70 Decreased fetal movements unspecified as to episode of care or not applicable

655.71 Decreased fetal movements delivered, with or without mention of antepartum condition

655.73 Decreased fetal movements antepar-

"Diagnosis Codes determine whether you get paid." Joyce Nurenberg

Have you ordered your 1998 ICD-9 Coding Manual?

More 5-digit coding is being introduced, forcing physicians to code to the highest specificity. Contact Joyce Nurenberg at (571) 336-5722 for ordering information.

	tum condition or complication	V42.81	Organ or tissue replaced by transplany,
686.00	Other local infection of skin and subcu-		bone marrow
686.01	taneous tissue, pyoderma, unspecified Other local infection of skin and sub-	V42.82	Organ or tissue replaced by transplant, peripheral stem cells
	cutaneous tissue, pyoderma gangrenosum	V42.83	Organ or tissue replaced by transplant, pancreas
686.09	Other local infection of skin and sub- cutaneous tissue, other pyoderma	V42.89	Other organ or tissue replaced by transplant
756 70	Congenital anomaly of abdominal wall,	V45 61	Cataract extraction status
150.10	unspecified		Other states following surgery of eye
756.71	Congenital anomaly of abdominal wall,	, , ,	and adnexa
	prune belly syndrome	V45.71	Acquired absence of breast
756.79	Other congenital anomalies of abdominal wall	V45.72	Acquired absence of intestine (large (small)
780.31	Febrile convulsions	V45.73	Acquired absence of kidney
780.39	Other convulsions	V53.01	Fitting and adjustment of cerebral ven-
790.94	Other nonspecific findings on exami-		tricular (communicating) shunt
	nation of blood, euthyroid sick syn-	V53.02	Fitting and adjustment of
	drome		neuropacemaker (brain) (peripheral
796.5	Abnormal findings on antenatal		nerve) (spinal cord)
	screening	V53.09	Fitting and adjustment of other devices
	Head injury, unspecified		related to nervous system and special
	Injury of face and neck		senses
	Viral hepatitis carrier, unspecified	V64.4	Laparoscopic surgical procedure con-
	Hepatitis B carrier		verted to open procedure
	Hepatitis C carrier	V76.10	Screening for malignant neoplasm,
	Other viral hepatitis carrier		breast screening, unspecified
V12.40	Personal history of unspecified disorder of nervous system and sense organs	V76.11	Screening mammogram for high-risk patient, malignant neoplasm of breast
V12.41	Personal history of benign neoplasm of the brain	V76.12	Other screening mammogram for malignant neoplasm of breast
V12.49	Personal history of other disorder of	V76.19	Other screening breast examination for
	nervous system and sense organs		malignant neoplasm
V16.40	Family history of malignant neoplasm		•
	of genital organ, unspecified	Revise	d Codes
V16.41	Family history of malignant neoplasm	041.04	Streptococcus infection in conditions
	of ovary		classified elsewhere and of unspecified
V16.42	Family history of malignant neoplasm		site, Group D [Enterococcus]
	of prostate	474.0	Chronic tonsillitis and adenoiditis
V16.43	Family history of malignant neoplasm	959.0	Injury, other and unspecified of head,

V16.49 Family history of other malignant neo-

V28.6 Antenatal screening for streptococcus B

continued on page 22

face, and neck

Marigowda Nagaraju, MD

Making a difference in Flint

By Ralph D. Ward

espite the financial attractions of a career in medicine, physicians need more than dollar signs to sustain them through the heavy costs and pressures of medical training and building a practice. The belief that being a physician is the ultimate career choice for doing social good is a key part of any doctor's total philosophy.

But after becoming established in practice, finding ourselves overwhelmed daily by time demands, worries and administrative burdens, what then?

Then, it does us good to consider the example of Marigowda Nagaraju, MD, a Flint area gastroenterologist with a successful solo practice. After a busy day, he gives a substantial part of his time to a second career — making sure that Flint's working poor have a source for free medical care.

Doctor Nagaraju came to Michigan in 1970, after medical training in his native India and in England. "I had a chance to work with Doctor Shelia Sherlock at the University of London," relates Doctor Nagaraju "She was one of the world's best known liver specialists, and she recommended that I take my GI training in Ann Arbor. I did, and then came to Flint to practice."

Flint in the early 70's was beginning to feel the pinch of hard times in the auto industry, and Doctor Nagaraju saw some of the local population's primary care needs going unmet. "Some of us in the Indian community decided we had to do some service for the community at large, and in 1974 we started holding free clinics, volunteering our services," he recalls. "Unfortunately, rising liability insurance premiums soon made such service prohibitive, and in 1977 they were halted."

Though this first effort came to an end, the need continued to grow. In 1987, the University of Michigan surveyed state health care coverage, and used Flint's Genesee County as a testbed.

Doctor Nagaraju was a source for the county's figures, and was concerned when he saw the results. There were 13,000 people without health care coverage. These working poor did not qualify for Medicaid or Medicare benefits, and lacked health care insurance, leaving them dangerously exposed.

Doctor Nagaraju saw the numbers as cause for a new commitment to volunteer medical care. "A number of us in the community decided to set up a permanent free clinic for these people," he says.

Despite the need, Doctor Nagaraju and other local physicians and community leaders faced many obstacles in creating a new free health care clinic, foremost of these being the cost of liability coverage. However, by 1990, Flint's Community Foundation offered a grant to fund the needed insurance, and the Genesee County Free Medical Clinic finally became a reality. The clinic, located on Saginaw Street in Flint, operates from 5:30 p.m. to 8:30 p.m. weekdays, and is completely staffed by volunteers. There are two doctors on duty, a resident, four nurses, intake staff and a pharmacist. The clinic has formed a local health care volunteer network of 50 primary care physicians and 150 specialists who volunteer time at the clinic or accept referrals at no charge. Doctor Nagaraju has found physicians are quite willing to volunteer their time, even when it comes at the end of a long day of regular duties. "It really doesn't take much convincing," he says. "We just have to ask them." Physicians typically volunteer nine to 12 hours yearly.

The clinic offers vitally needed services to those who fall through the health care net, including free medications and referrals for tests. Three local hospitals have joined the network, volunteering their services and facilities. A board of area physicians, community and business leaders, and hospital CEOs supervises the clinic,

"It takes a
good lot of my
time, but I'm
happy to do
it," he says.
"We are well
paid by those
who pay us,
and I believe
we have a duty
to offer our
services.

Doctor Nagaraju

Doctor Nagaraju recently was recognized by MSMS during "Doctors and Their Families Make a Difference" day—October 25, 1997.



Doctor Nagaraju, center, accepts a donation for the free clinic from GM and UAW representatives.

which treated 1,900 patients last year. The Genesee County program has become a model for success in the state, with Detroit planning its own clinic system using Flint as a blueprint.

As for Doctor Nagaraju, the personal satisfaction he feels in the clinic's success more than

outweighs his long hours. "It takes a good lot of my time, but I'm happy to do it," he says. "We are well paid by those who pay us, and I believe we have a duty to offer our services."

The author is a Riverdale-based freelance writer.

"ICD-9 Codes" continued from page 19

Deleted Codes

038.1 Staphylococcal septicemia 275.4 Disorders of calcium metabolism 438 Late effects of cerebrovascular disease 474.0 Chronic tonsillitis and adenoiditis 474.0 Other local infections of skin and subcutaneous tissue, pyoderma 756.7 Other congenital anomalies of abdominal wall 780.3 Convulsions 959.0 Injury. Other and unspecified of head, face, and neck V02.6 Carrier or suspected carrier of viral hepatitis V12.4 Personal history of disorders of nervous system and sense organs

V16.4 Family history of malignant neoplasm

- of genital organs V42.8 Unspecified organ or tissue replaced by transplant
- V45.6 Other postsurgical state following surgery of eye and adnexa
- V53.0 Fitting and adjustment of devices related to nervous system and special senses
- V76.1 Special screening for malignant neoplasm of the breast

For questions or additional information, please contact MSMS Reimbursement Ombudsman, Joyce Nurenberg (517) 336-5722; or email her at jnurenberg@msms.org.



Your coding life will change on January 1, 1998

New E & M documentation guidelines will be required as of January 1998.

MSMS Center for Physician Education and Leadership is offering "Coding for Physicians," a three-hour workshop to prepare physicians and their staff for these changes. This seminar is being presented in three locations in January. Be sure to partake of this opportunity immediately.

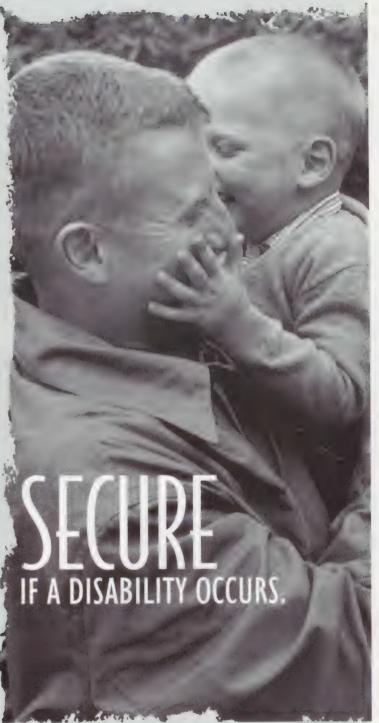
- January 20, 1998: Kalamazoo, The Radisson Plaza Hotel at Kalamazoo Center—6-9 p.m.
- January 22, 1998: Muskegon, The Holiday Inn, Muskegon—6-9 p.m.
- January 29, 1998: Okemos, The Michigan Public Health Institute—6-9 p.m. (This seminar will also serve as a telecommunication site, so it can be accessed from several location statewide.)

MSMS also will bring this reasonably priced workshop to groups upon request. For more information, or to schedule this workshop please call Mary Jensen at (517) 336-5706, or email her at mjensen2@msms.org; or call Deborah Zannoth at (517) 336-5767, or e-mail her at dzannoth@msms.org.

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Mergers and acquisitions have taken many puzzling shapes for thousands of Michigan physicians in recent years, sometimes leaving them wondering where they fit in. The mergers take many shapes—from single physicians joining practices, to specialties contracting for services, to clinics affiliating with hospitals, to the amalgamation of hospital giants.

This month's cover story begins a series of articles which will appear in Michigan Medicine over the coming months exploring the impact of the many types of mergers in physicians' lives. This first article spotlights the merger of hospitals, especially the Butterworth/Blodgett merger in Grand Rapids. With each offering we will provide guidance for MSMS members, to help them survive and thrive in the jigsaw of change. MSMS believes that physicians are the key piece in the delivery of the medical care puzzle, and that all else has to form around them. MSMS dedicates its efforts to assure physicians understand, appreciate and play their pivotal role.

Coping with change in the health care marketplace

By Karen Bouffard

conomics — questions of who should control local health care, the need to contain costs, problems of aging facilities and concern over needless duplication of services — are behind the growing trend of hospital mergers in Michigan. But how decision-makers handle the "human" aspects of a merger — variables such as traditions, rivalries, pride of ownership and institutional distrust — can either ease the process or breed suspicion and discontent.

The sometimes rocky road leading to blended institutions has been traveled by physicians in Monroe, Jackson, Bay City, Lansing, Traverse City and elsewhere. As MSMS Physician/Hospital Relations Director F. B. "Tom" Plasman observes, "In some cases staffs have been joined like a shotgun wedding . . . and in others with great collegiality."

One of Michigan's newest mergers is taking place in Grand Rapids, where Blodgett Memorial Medical Center and Butterworth Health Corporation have formed a new corporate entity—Spectrum Health. As that new entity takes shape, Michigan Medicine explores how hospitals and physicians can ease the process of change.

Health care at a crossroads

Proponents say the Butterworth/Blodgett merger will save \$170 million over five years, prevent loss of local health care control to forprofit predators and result in a tripling of the amount the two hospitals previously spent for indigent care. While promises have been made to freeze Spectrum's prices for three years, skeptics, including some employer groups, labor unions and insurance companies, are concerned about Butterworth's reported 16 percent profit margins and strong relationship with Priority Health, Butterworth's own managed care plan.

At worst, critics fear the potential for abuse of Spectrum's 70 percent market share in the Grand Rapids area.

Anti-trust regulators tried twice in court to block the merger. believing its resulting monopoly would hurt consumers. But U.S. District Court Judge David McKeague in Lansing and also the Sixth U.S. Circuit Court of Appeals in Cincinnati refused to grant injunctions. In an unprecedented move, the FTC pursued

yet another avenue of opposition, calling for an administrative hearing to decide if the merger violated anti-competition laws. In the meantime, tired of waiting for federal approval, the two hospital boards voted on September 22 to

Uncertainty as to the merger's future ended September 26 when the FTC announced it had dropped its opposition, clearing the way for the giant new healthcare company to proceed un-

According to Brian L. Hotchkiss, MD, a practicing pediatric orthopedic surgeon and Chief of Staff at Blodgett, the turnaround followed "astute questioning" of the FTC by political leaders, including U.S. Sen. Spencer Abraham, R-Mich., and U. S. Representative Vern Ehlers, R-Grand Rapids, who were "incensed that the FTC would go through a full week of hearings in Lansing, and then through appeals court and now go through an administrative process that could spread out over a long period of time." Further pressure was applied when language was included in the Commerce Justice State Appropriations bill that would have prevented the FTC from holding the hearing.

Doctor Hotchkiss said the lengthy and difficult process began in 1993 between "two very similar hospitals, both financially very secure." Each had been named more than once, in re-



Blodgett Memorial Medical Center

cent years, as "top 100" hospitals in their divisions.

"As two smaller competing hospitals, the projection was that our state of financial health would not last forever," Doctor Hotchkiss said. "Eventually one or the other would become more vulnerable to a take-over by a for-profit."

R. Paul Clodfelder, MD, is immediate past chief of staff for Butterworth, leaving that post in July 1996. Now working part time for Butterworth at Pine Rest while volunteering part time with indigent patients at West Side Health Services, he was in a leadership role through much of the merger process.

According to Doctor Clodfelder, the merger idea arose from the findings of the Alliance for Health's Hillman Commission, a 23-member citizens' advisory council that spent more than a year studying local health care institutions. As a result of discussions with the commission, the two institutions' chief officers, Butterworth Health Corporation Chairman and Amway Cofounder Richard DeVos and Blodgett Chairman David J. Wagner, began talking about a possible merger.

Wouldn't it be good to merge?

"Blodgett was going to build a new health complex, and Butterworth wanted to build the South Pavilion, a surgical center with doctor's offices. The commission said, 'Why don't you work together?" Doctor Clodfelder recalls. "The commission advised Butterworth to look for cheaper land on the Pine Rest campus, and advised the two hospitals to cooperate in joint services. DeVos and Wagner said, 'Wouldn't it be good to merge the two hospitals?' They came up with some tremendous savings by not build-

According to Doctor Hotchkiss, trying to describe how physicians feel about the merger, "is like trying to describe whether the glass is half empty or half full."

"When this merger was first raised, the physicians who were in the leadership roles - the department chairs and chiefs of staff were in favor of it. The administration had their reasons for it. but for the physicians it was for the opportunity to improve quality of care for the community."

ing a new hospital for Blodgett, and by combining some new services."

"They were looking at spending a lot of money through duplication of services. Blodgett was land-locked, and would have had to build a new hospital. With the merger, there will be major savings. We don't have to build a whole full-scale tertiary care hospital," adds Doctor Hotchkiss.

According to Doctor Hotchkiss, trying to describe how physicians feel about the merger, "is like trying to describe whether the glass is half empty or half full. It's a wonderful opportunity to combine some resources that had been scattered and create a much better treatment milieu. Those who are threatened see it as a loss of a traditional institution."

"There's the sentimentality of practicing in the same hospital you've been at for 20 years, where your father interned, and your grandfather practiced."

For the time being, the two hospitals will retain their separate identities. But within one year, the institutions will forego their historic names for new Spectrum identities. The current Butterworth site will become the Downtown Campus of Spectrum Health, while East Campus will be located where Blodgett now sits.

Taking on a new identity

"The nature of the merger is that each of the two systems is discarding its identity, and taking on the identity of Spectrum Health," Doctor Hotchkiss said. "We're now talking of fazing out Blodgett. Virtually all intensive care hospital work would take place on the downtown — Butterworth — campus. The Blodgett campus would be for out-patient and short hospital stays."

Doctor Hotchkiss adds, "This has led to discomfort for physicians: the Blodgett physicians because they have to work in somebody else's hospital; and the Butterworth physicians, because they face having to spread their services over two hospitals."

According to Doctor Clodfelder, a survey conducted by the Kent County Medical Society showed that Butterworth physicians supported the merger by two-to-one, while Blodgett physicians opposed the change by two-to-one.

"There is still quite a lot of opposition by the Blodgett physicians," Doctor Clodfelder notes. "Some Blodgett physicians are disappointed that they're not going to get their new hospital, and they will have to leave their old hospital and go downtown to Butterworth. Also, many will have to go to two different sites."

Practical considerations are of concern to many physicians, Doctor Hotchkiss adds. "It's the going into somebody else's business, and trying to find a place. You take all the physicians from both hospitals and say, 'Who gets the operating room slots? Who's going to get the best time slots?""

Issues of economics, issues of the heart

While it's too soon to predict outcomes, both Doctor Hotchkiss and Doctor Clodfelder feel the Butterworth/Blodgett merger will be for the best.

"On the positive side, there's a lot for the community to gain," Doctor Hotchkiss said. "When this merger was first raised, the physicians who were in the leadership roles – the department chairs and chiefs of staff – were in favor of it. The administration had their reasons for it, but for the physicians it was for the opportunity to improve quality of care for the community. There were more positives than negatives – and more yet as the process went on."

Doctor Clodfelder, as a volunteer, looks forward to the \$6 million per year for indigent care the merger will provide. "I'd rather see \$6 million for indigent care than \$6 for duplication of services," he said. "It's going to save some major money. As a volunteer, I appreciate that."

Donald L. Fraser, DO, is a staff physician in the Department of Family Practice and a mem-

Brian L. Hotchkiss, MD



Butterworth Hospital

ber of the Board of Directors of Munson Health Care, parent organization of Traverse City's Munson Medical Center. Doctor Fraser is a four-year veteran of Munson's merger with Traverse City Community Hospital (previously Traverse City Osteopathic Hospital.) Prior to the 1993 merger, Doctor Fraser was on staff with Traverse City Community, and a member of its Board of Trustees.

Doctor Fraser understands the impact of words like "tradition" and "sentimentality" in the merger process. Today, Traverse City Community Hospital no longer exists. The old hospital has been torn down, and in its place sits a new Community Health Center with urgent care walk-in services, a rehab center, pain clinic and many other new services.

"The bottom line is, it was a very good move for us here in Traverse City. It's solidified the

medical staffs – instead of the two of us looking at each other from a distance," Doctor Fraser said. "I'm convinced it was a win-win situation. It had to happen."

Scott Bosch, vice President and CEO of Munson Medical Center said that - unlike the Grand Rapids situation of mutual financial health - Traverse City had two hospitals just four miles apart, with one, Traverse City Community, struggling to survive. "Traverse City Community had a well-aging physical plant with equipment in need of replacement. It had been losing money," Bosch said. "Previously Munson Health Care had acquired the assets of Traverse City Community. The decision was made in 1993 that due to declining profitability the merger was necessary."

Bosch notes that by merging, Munson became the sole community provider, a move that

Doctor Fraser shares this advice for physicians facing a hospital merger: "Be just as involved in the process as you can be, and stay informed."

Physicians' natural desire to share healthcare information among themselves is a positive factor in merger situations.

brought in millions of dollars per year in Medicare reimbursement. "In a rural area, being the sole provider brings an increase in the wage component of Medicare reimbursement, which brought us up to the urban level," Bosch said. "This was a several million dollar per year factor, combined with another several million in cost reductions. This was all accomplished without affecting negatively the quality of care."

Bosch said the major concern of the merger was the blending of Munson's large allopathic staff of about 250 physicians, with Traverse City Community's small osteopathic staff of less than 50. "We had a few physicians that were members of both staffs, but for the most part the staffs were very separate - and there had been some bad blood between the two over the years. That turned out to be the smoothest part of the merger. The Munson staff threw open the doors, and said 'anybody on staff across town is on staff here."

Bosch added, "The osteopathic physicians have added a great deal of quality to the organization. They're in the minority, but they've been very well received. The medical staff issue was just not an issue."

According to Doctor Fraser, "Munson had talked about wanting to merge the two institutions for a fair number of years, but there was some mistrust – and a great deal of independent thinking about wanting to make Traverse City Community Hospital work.

"One of the features of small hospitals is a tremendous amount of effort from the community, as well as from physicians, who volunteer to do work that in a bigger hospital would be done by administrative staff. So we had this intimate connection between the medical staff and the administration - all this tight-knit group who were trying to make it work.

However, "There are people who struggle with that sense of loss yet today." Doctor Fraser adds, "There used to be a sense of competitive atmosphere, and we always thought that it spurred us on to meet the needs of the community. Now the economies of scale are such that the medical needs of the community will be met better than ever before."

Easing the process

Doctor Fraser shares this advice for physicians facing a hospital merger: "Be just as involved in the process as you can be, and stay informed."

According to Doctor Fraser, "The biggest problem is with physicians who aren't informed and don't understand the reasons behind the merger - or who don't buy into it. As a member of the Board, I was part of all the investigation, the discussions, and the alternatives that were considered. Being aware helped me through the process."

He added, "There has to be a liaison between the Board of Trustees and the medical staff to be absolutely sure there's nothing under the table – or that there is no perception of something under the table. There's always the idea that somebody's going to be gored."

Carl G. Benner, MD, corporate vice president for medical affairs at Munson, said there was an effort to improve relationships between the two staffs even before the merger.

"There had always been a segment on both staffs that were not interested in having the merger go through. A lot of staff were concerned about what would happen to their privileges at Munson. We identified up front how we would handle credentialing. We did identify several physicians with whom we would have some problems. It was clear from the outset that there were a few who would not participate. Eventually we had fallout of only about five people.

"The best thing we did was being honest and forthright, and having the credentialing committee involved from the very start," Doctor Benner said, adding that osteopaths have taken major leadership roles at Munson. Chiefs of the Laboratory, Cardiology and Emergency Medicine are osteopaths from the former Traverse City Community Hospital. In addition, osteopaths are represented on the block scheduling committee, executive committee and other hospital decisionmaking bodies.



William G. Gonzalez

In Grand Rapids,

according to Doctor Hotchkiss, "We have made it clear that this would not come by dictum, but by a great amount of physician involvement."

Of 24 members of the Spectrum Heath Board of Directors, four are physicians – two from each hospital. In total, the Board is comprised of eight representatives from each hospital, and eight members of the community. A Physician Merger Task Force, comprised of 10 physicians from each of the two hospitals, has been meeting regularly for a year and a half.

"All of the documents, and everything done, has been structured as a merger of equals, with everything down the middle," Doctor Hotchkiss said, noting that Blodgett President Terrence M. O'Rourke will serve as Spectrum's president and CEO for the first 18 months. William G. Gonzalez, current president and CEO of Butterworth, will then take over for 18 months—he is chief health system officer of Spectrum during the first 18 months.

In his role as director of physician/hospital relations at MSMS, Plasman has witnessed numerous mergers throughout the state. According to Plasman, physicians' natural desire to share health care information among themselves is a positive factor in merger situations.

"There is the peculiarity in the practice of medicine that if 'Doctor A' learns something new, he/she can't wait to share it with his/her colleagues. It's the inborn nature of physicians," Plasman said.



Terrence M. O'Rourke

"What we're seeing now is this physician spirit working its way into the business of health care, so vou're seeing hospitals begin to work together. A major reason for mergers is, of course, M-O-N-E-Y. But this other philosophy, which has gone unheralded, is

starting to have an impact," Plasman added. "Are there doctors who don't get along? Of course. We're all human beings. But most of all there has been increased cooperation among physicians as new treatment modalities have been developed."

This sense of collegiality has already had an impact among laboratory staffs of Butterworth and Blodgett. According to Peter VanVliet. MD, chair of the Butterworth Department of Pathology and Clinical Laboratories, the transition so far has been smooth for the laboratory staffs of both hospitals.

"We understand that this type of thing is happening across the country, and when all is said and done the long-term affects are beneficial," Doctor VanVliet said. "We're all pledged to make it happen and make it work."

He added, "Our staffs compliment each other very well, and there is an interest in both groups to get along with the merger to achieve some degrees of excellence we haven't been able to reach before. In the lab, we're all very eager to accomplish the merger."

Doctor Hotchkiss said he likes to think that efforts made to make the Butterworth/Blodgett merger smooth and equitable for all had some influence on the FTC's decision to back away from opposition.

He said, "Maybe our walking the talk had something to do with it."

The author is a Williamston-based freelance writer.

The 'U' word.

Physicians and unions: What's the possibility?

It is noted that physicians provide an attractive target for recruitment efforts at a time of sagging union membership and often unsettling change in the medical profession.

atest analyses show that 29 percent of MSMS members now are in some form of employee status. Can employed physicians form unions? Should they? What would union formation involve? The following article is presented by the MSMS Committee for Corporate Affiliated Physicians, as the first in a series which will address concerns of these members. This article is excerpted from a comprehensive report on physicians and unions adopted by the AMA House of Delegates in June 1997 (BOT Report 41-A97).

This excerpt presents the executive summary of the report, plus the section on the legalities of physicians forming unions. Other sections provide a status report on physician unions, discuss the costs of forming a union, suggest supportive state society activities and detail AMA actions regarding unions. MSMS believes the report provides the best current update on the subject. It is available in its entirety on the MSMS home page at http://www.msms.org/, or by contacting Mary Anne Ford at MSMS headquarters, (517) 336-5721; (517) 337-2490 (fax), or maford@msms.org.

-F. Remington Sprague, MD, Chair MSMS Committee for Corporate Affiliated Physicians

This report responds to the current upsurge of interest in unions by physicians in certain parts of the country. This has been fueled by several high profile physician-union affiliations and media accounts of this activity. The heightened interest in unions comes at a time when physicians feel increasingly powerless to respond to the tremendous leverage exerted by health plans. Although the promise that union affiliation will provide physicians with more clout clearly strikes a chord, it is a promise that will inevitably prove

false, because unions cannot, in fact, do anything more for physicians than state and county medical societies.

It is noted that physicians provide an attractive target for recruitment efforts at a time of sagging union membership and often unsettling change in the medical profession. However, although physician unions have existed for years, they historically have represented publicly-employed physicians and residents. The total number of members is currently somewhere between 14,000 and 20,000, including between 6,000

and 9,000 residents, a large number of publicly employed physicians and approximately 3,000 independent-practice physicians.

Why physicians are interested in union formation

Physicians who are interested in unions fall into two categories: those who are self-employed and those who are employees of group practices, hospitals or another entity.

Self-employed physicians are interested in unions because managed care health plans have obtained a significant amount of economic leverage over physicians. This leverage has enabled health plans to assume substantial control over medical decision-making for patients, to drive down the incomes of many physicians and to threaten the viability of some physician practices. Physicians have felt powerless to respond to this trend. Federal and state antitrust laws bar any collective action, such as boycotts, that would allow physicians to force health plans out of a market by refusing to participate on their panels.

Some health plans have not used their leverage solely to drive down costs. They have engaged in conduct that has been arbitrary,

Unionization update

Wayne County Medical Society (WCMS) will be holding a seminar on physician unionization. The seminar, "Unionization, Pro and Con," is co-sponsored by the Macombe County Medical Society—and contains two parts—"Is There a Union in Your Future?" and "Advocacy through Medical Societies." This is an excellent opportunity for you to stay informed about such an important topic.

The seminar will be held at WCMS on Wednesday January 7, 1998.

To enroll in this course, or for more information, please call Alice Waite, at WCMS at (313) 567-1640.

unfair and generally cavalier toward physicians. These health plans believe that if they treat some physicians badly, they have enough economic leverage to get away with it. Often, they have. Self-employed physicians have felt powerless to defend themselves from these abuses.

This has led self-employed physicians to explore whether union formation will allow them to respond to the economic leverage of health plans with leverage of their own.

Employed physicians often became employees to escape the insecurity of being self-employed in the current environment. They have sought security of position and income, and protection from abusive practices by health plans. However, some employed physicians have become disenchanted with practices of their employers. Some employers have demanded reductions in income, or have issued non-negotiable directives to their employed physicians. As a result, these employed physicians also have become interested in forming unions to engage in collective bargaining with their employers.

The labor exemption from the antitrust laws

The law of union formation involves a complex interplay of antitrust and labor law. Independent, self-employed physicians are not in an employment relationship and therefore cannot engage in collective bargaining under the National Labor Relations Act. Those that do, whether through a union or other entity, will be violating the antitrust laws and subject to significant penalties.

There is a conflict between the goals of the antitrust laws and the labor laws. The purpose of the antitrust laws is to promote competition among providers of goods and services as a way to enhance consumer welfare. Competition leads to greater diversity among products and services, better quality and lower prices. Therefore, the antitrust laws bar combinations and other collective actions among sellers or buyers of goods and services to raise prices or otherwise set the terms of dealing.

The antitrust laws are broad enough to cover human labor. Originally, federal cases found that labor was subject to the antitrust laws, and collective activities among laborers designed to raise or standardize wages or affect the terms of dealing between workers and employers were illegal. Such activities had to be expressly exempted from the antitrust laws.

Source of the exemption

The exemption itself is the product of five sets of statutes and judicial case law. It is set forth in Section 20 of the Clayton Act. The Clayton Act is a set of antitrust laws passed in 1914, which further bars federal courts from entering injunctions against specified types of conduct "involving or growing out of a labor dispute."

However, the Clayton Act is not specific about what constitutes labor organizations and their activities, so four other acts are referred to in order to interpret the scope of the exemption. The first is the Norris Laguardia Act passed in 1932, which declared a national public policy in favor of labor unions and stated that collective bargaining and union organization are protected activities. This act specifically designates nine categories of activities that are protected **Employed** physicians often became employees to escape the insecurity of being selfemployed in the current environment.

continued on page 58

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The Clarksons-Jack, MD and Tess, MD

Partners in life, bractice and music

By Ralph D. Ward

I ichigan has a number of "his 'n her" medical practices, with a husband and wife team working together. But Doctors Tess and lack Clarkson of Ovid carry their partnership even further, with a hobby/sideline that keeps them busy and successful—in the world of music.

For the past 10 years, the Clarksons have operated a general practice in the small southern Michigan community of Ovid. Jack Clarkson, MD, who grew up in the urban Detroit area, completed his education at MSU in 1979, and spent some time practicing emergency medicine at the hospital in nearby St. Johns. "It was my first rural exposure, and I thought it made a beautiful change," he recalls. At about the same time as his graduation, Doctor Clarkson married fellow medical student Tess, who shared his interest in the country lifestyle, as well as his goal of general family practice.

The hand of fate

About 10 years ago, a friend who owned a building in Ovid mentioned that his tenant, a physician, was leaving the area. Jack and Tess Clarkson saw the hand of fate, and seized the chance to launch their own rural practice. Their two-person setup offers the Doctors Clarkson an opportunity to shape a practice uniquely suited both to the needs of the area and to their own individual talents.

"We're on an equal par," notes Doctor Tess. "We're both in family practice, but I do more of the female medicine, he handles more of the gerontology, and we both work with children." Good relationships with staff at the nearest hospitals (Owosso and St. Johns-both almost 20 miles away) allows the Clarksons to avoid long drives to handle admissions in person. The practice is open three days weekly, which gives the doctors the flexibility to do other things, according to Doctor Jack.

What other things? How about a successful sub-career in music?

The Clarksons both play in two local country and gospel bands, he on the fiddle and guitar, she on keyboards. Jack's career in country and bluegrass music extends back to his college years,

when gigs with his group, "Bluegrass Extension Service," helped pay his way through MSU.

Rubbing elbows with the masters

In the 1980s, he recorded an album in Nashville with fiddle great Vassar Clements. Doctor Tess is a classically trained pianist (she's the one who actually reads notes, observes Doctor lack).

The couple's country group, "Great Lakes Country Club Band," is a tight, professional ensemble that includes the Clarkson's, steel guitar player Glen Paul, guitarist Ron Bradley, bassist Eldon "Hougie" Hofacker and drummer Bubba Grudner. This ensemble is no casual pickup group either. The band averages 100 gigs a year, and Glen Paul has a long career in Nashville, playing at the Grand Old Opry with such talents as Don Williams, and touring internationally.

On the gospel music trail, Doctor Jack is music director for the couple's local church, and the duo tour locally with a smaller version of their band, playing religious music. The latter is taking a growing place in the Clarkson's life. "We're cutting back on the music, except for the gospel," notes Doctor Jack. "It is just too much."

And horses, too!

But freeing more time won't necessarily mean more hours in the office. The Clarksons own a farm outside of Ovid, and Tess is dedicating more involvement to their horse-raising operation. "We have four Arabian horses-Sheik (pictured), Eclipse, Icy and Zach," she notes.

"We're both in family practice, but I do more of the female medicine, he handles more of the gerontology, and we both work with children." Tess Clarkson, MD



Doctors Tess and Jack Clarkston and their stallion, Sheik

The pair are together almost constantly in their shared full-time lifestyle of medicine, music and farming. Do they ever get on each other's nerves?

"Apparently not — we enjoy it!" says Doc-

tor Tess. "There's not a complaint . . . we love it!" says Doctor Jack. Sounds like close gospel harmony.

The author is a Riverdale-based freelance writer.



Rural family practice

The dream and the reality

By Craig K. Matheson, DO

hen my aspiration to become a physician materialized some time during my teenage years, I envisioned myself as a rural family doctor. An undeniable influence was received from Marcus Welby as I dreamed of a monument in the town square immortalizing the family doctor. Having grown up in a suburb of Detroit and studying medicine in Chicago, my exposure to rural family practice was limited. Nevertheless, my aspiration for skilled and motiis now a reality and I practice in Newaygo County.

Although every bit as fulfilling as I had settings continues to be high. hoped, what makes this so in a rural setting is not what I anticipated. I expected to be an in- practice is the lifestyle. Once I tegral part of the small community where I prac-struck a balance between profesticed and to have close relationships with three sional demands and personal life, I and four generations of patients. This much is was able to appreciate the slower true, and I even receive gifts of garden pickles and handmade quilts from my patients on oc-

Yet I didn't realize how professionally chalceed, and I can see them many times lenging and diverse rural medicine would be. throughout my work-week at the Without a full complement of specialists in the office, home for lunch or with their area, family practice physicians manage a preschool class that is visiting the broader range of medical and social problems office for a field trip. The realities of in the office and in the hospital than would be rural family practice for me far outtrue in an urban setting.

Opportunities to fill community need outweigh the supply of physician troops in most Doctor Matheson is a family rural settings. This has allowed me to serve as medical director for Hospice, as a local consultant for Children and Adults with Attention

Deficit Disorder and medical consultant for the hospital's in-patient psychiatric unit.

These roles help me to see the big picture of health care today. Ways to influence it seem much more apparent in a small community. The demand vated family practitioners in rural Michigan

An added benefit to rural family pace and beautiful setting Newaygo County has to offer. My children have "the village" they need to sucshine the dream.

practicioner and director of Hospice in Newaygo County.

"The demand for skilled and motivated family practitioners in rural Michigan settings continues to be high."

Doctor Matheson



Doctor Matheson and his daughter, Kate, busy at work during spring planting, as daughter Tess watches from picnic table, (rear)

Would you like to share the spotlight?

Doctor Matheson was approached by Michigan Medicine to write a "spotlight" piece on practicina medicine in a rural environment. If you are interested in writing a short feature for Michigan Medicine, highlighting an interesting aspect of your practice, please contact Judy Marr, Editor at (517)336-5744; or e-mail her at jmarr@msms.org.

38 Michigan Medicine December 1997

MSMS joins AMA, national specialties in fourth case study

SSPNs offer specialty physicians market opportunities

By Thomas M. Gorey, JD and Nancy K. Bannon, JD

ust a few years ago, it was suggested that specialists "re-tool" themselves by becoming primary care physicians. Today, specialty physicians are surviving and in many cases thriving under managed care by reconfiguring their contracting strategies. One important new contracting strategy has been the creation of single specialty physician networks (SSPNs).

A study of SSPNs recently has been completed that looks at how these networks are being formed and operated. The Case Study Analysis of Single Specialty Physician Networks co-sponsored by the AMA, MSMS, the American Academy of Otolaryngology, the American Urological Association, the American Society of Plastic and Reconstructive Surgeons, the American Academy of Pediatrics, the American Academy of Dermatology and the American College of Radiology—compiled seven case studies of SSPNs in order to help physicians explore this organizational strategy.

Although the SSPNs in the study are located in different regions, have different size memberships and are at different stages of development, they share a number of common charac-

Strong physician leadership

The most notable common characteristic among the networks is the presence of a strong physician leader who has been instrumental in formation of the network and who serves as the hub of the network. These physicians are respected for both their clinical skills and business sense. The physician leaders have strong interpersonal and organizational skills. They usually are persuasive, decisive and willing to "take the heat" for their decisions. The physician founders of specialty networks make major time commitments to organizing and operating the networks, in some cases simultaneously acting as president, medical director and network administrator.

Minimal capital

The SSPNs tend to be very modestly capitalized. Members of SSPNs view the limited commitment of capital as one of the main benefits of the network form of organization. The nominal finan-

cial contribution required from members is often a selling point for network membership. In order to keep the expenses of forming a network to a minimum, SSPNs use consultants and attorneys sparingly, bringing in needed legal and consulting expertise only after the core physicians have formulated a basic organizational and strategic approach.

Narrowly focused strategic plan

SSPNs view themselves primarily as vehicles for gaining access to managed care contracts and improving contract terms. The specialists forming SSPNs are seeking a way to empower themselves in the market, while maintaining as much autonomy as possible. Their business planning process tends to be informal, abbreviated and physician led. Specialty networks are designed around payers' needs and often reflect payer input. In fact, a payer's specific request for a specialty network, or a payer's intent to contract with a third-party administrator for specialty services, often is the precipitating event leading to creation of a network.

Selective membership

Single specialty networks generally are very selective in choosing their physician members. Their members are like-minded physicians who accept the reality of managed care. Most networks begin with a small panel of specialists, which is attractive to payers, and add physicians based on payers' geographic and subspecialty

Members of SSPNs view the limited commitment of capital as one of the main benefits of the network form of organization.

needs. Network members are almost always board certified and on occasion hold dual board certifications. Physicians generally do not participate in SSPNs on an exclusive basis and often are affiliated with several



Thomas M. Gorey, JD

different IPAs, PHOs or other provider-sponsored contracting entities.

Streamlined governance

A streamlined governance structure prevails in SSPNs, marked by informality and limited committee activity. SSPN members often have empowered their leaders to make decisions and to act on their behalf. These leaders often serve as "benevolent dictators," who "call the shots" to a large extent. An SSPN is run as a business, not a democracy: unlike some other types of physician-run organizations, decisions are not made through a consensus of membership.

Minimal administrative expenses

Single specialty networks seek to minimize administrative expenses in order to maximize payments to member physicians. SSPNs usually have a "bare bones" administrative staff, with physician leaders utilizing their own office staffs—at least initially—to provide administrative services for the network. As SSPNs mature and administrative functions become more time consuming, networks hire their own staff or purchase administrative services from management consulting firms or MSOs. Network physicians frequently are reluctant to expand network activities because of the additional administrative costs that



Nancy K. Bannon, JD

would be incurred.

Strong contracting relationships

SSPN contracting strategies emphasize early entry into the market and development of strong payer relationships.

There is a tremendous advantage to being the first network in the market for a given specialty. The success of a specialty network is built on strong, long-term relationships with pavers that emphasize high quality care to the patient and excellent customer service to the payer. For SSPNs, the payer can be an HMO or another physician organization, such as a primary care IPA, a multispecialty IPA or a group practice.

Payment based on utilization levels

SSPNs use a variety of physician payment mechanisms that usually incorporate some risk to the physician, based on utilization levels. Most SSPNs do not pay member physicians on a capitated basis—even if the SSPN is capitated by the payer. Physicians usually are paid either according to a fee schedule or based on the number of relative value units (RVUs) billed each month. In some cases, the fee schedule or the RVU value is adjusted upward or downward based on the utilization volume experienced by the SSPN each month. To encourage physicians to be "utilization efficient," some networks assign physicians to risk pool groups, where individual physician compensation is affected by the level of utilization for each group.

Meet demands for quality

SSPNs' quality assurance (QA) and utiliza-

Single specialty networks seek to minimize administrative expenses in order to maximize payments to member physicians.

needs. SSPNs emphasize the "value added" that their networks provide, often marketing themselves as offering a higher quality of care. Disease management is emerging as a key SSPN strategy for enhancing quality and for demonstrating a value-added benefit to payers. Although skeptical or resistant initially, members of SSPNs generally become supportive of network QA and UM efforts because the processes are developed and controlled by their peers in the network. **Modest information systems** It is likely that

SSPNs are utilizing information systems that are modest in design and cost, yet meet their needs for data on cost, quality and utilization. By using "off the shelf" software, SSPNs generally have been able to fill their information system needs without making large investments of capital. SSPNs in the study seldom had inhouse information systems expertise, so they brought in outside expertise on an as needed basis.

tion management (UM) activities evolve over

time in response to payer demands and network

Market key to future

What does the future hold for specialty networks? As with other strategies, the market holds the key. Currently, attitudes among payers toward specialty networks vary widely from market to market. For this reason, SSPNs tend to be clustered in certain markets, while other markets show little or no evidence of specialty networks. This situation is likely to persist, as physician and payer contracting strategies continue to evolve in a market-by-market fashion.

SSPNs have shown promise in their current form in being able to organize (and keep together) specialists, negotiate managed care contracts, manage risk and provide quality patient care. As they establish successful track records, many specialty networks will begin to look at ways to expand their activities. To expand in scope, however, will require more substantial capitalization, more significant administrative support, better information systems and more organizational structure than most networks currently have. Only time will tell whether the physicians participating in SSPNs are willing to provide the capital required to sustain a broader, more ambitious strategy. Much of the appeal of specialty networks to physicians has been the limited financial commitment that is required. Requiring a more substantial financial contribution will test the strength of specialists' commitment to these organization.

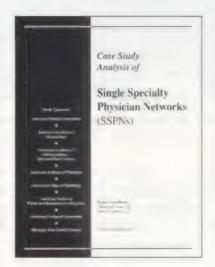
It is likely that many specialty networks will evolve into something else: fully integrated specialty groups, MSOs, physician practice management companies or other types of entities. A number of SSPN representative recognized the strong possibility that specialty networks, as presently constituted, may be a transitional model with a short life expectancy. As one official said, "the jury is still out as to whether capitated specialty networks are a long-play model."

Most specialty network representatives emphasized the need for SSPNs to remain flexible and to be open to new opportunities because changes in the market may necessitate organizational and strategic changes. Having accomplished their initial goal of organizing specialists and obtaining and managing contracts, many SSPNs expressed a desire to "move to the next level," wherever and whatever that may be.

Some or all of the following future scenarios are possible: (1) tighter integration of member practices under one corporate umbrella; (2) increased integration through selective practice acquisition; (3) expansion of network activities on a regional or national basis; (4) formation or expansion of a specialty MSO affiliated with the network or development of a strategic alliance with an independent, full-service MSO; (5) sale to a physician practice management company.

many specialty networks will evolve into something else: fully integrated specialty groups, MSOs, physician practice management companies or other types of entities.

Regardless of whether SSPNs are a permanent model or a transition toward a more farreaching strategic approach, the physicians who are participating in these networks are better positioned in the market than they otherwise would have been. Moreover, they have gained valuable experience with managed care and disease management that will place them in good stead as the health care market continues to change. As one physician said, "It has allowed us to be players and to have a seat at the table as the next level of evolution in the market takes place."



If you are interested in reading more about SSPNs, Order Now!

Case Study Analysis of Single Specialty Physician Networks (SSPNs)

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MSMS Bioethics conference tackles tough subjects

Physician assisted suicide hot topic at first event

By David K. Fox

"More than anything, the physician/ patient relationship is one of deep trust."

> Thomas R. Reardon, MD

valuations were enthusiastic from more than 100 participants at the first MSMS Mackinac Island Conference on Bioethics held at the Grand Hotel September 26-28 where issues included physician assisted suicide and genetic technology.

Planning already is underway for next year's Mackinac Island conference on October 2-4, 1998, at the Grand Hotel.

MSMS Bioethics Committee Chair Howard A. Brody, MD, PhD, hosted a dozen speakers including American Medical Association Board of Trustees Chair Thomas R. Reardon, MD, a Portland, Oregon, general practitioner, who spoke against physician assisted suicide. Speaking in favor of "assisted death" was Timothy E. Ouill, MD, a Rochester, New York, internist. Adding an international perspective was Doctor Ranaan Gillon, editor of Journal of Medical Ethics in London.

"More than anything, the physician/patient relationship is one of deep trust," Doctor Reardon argued. "The patient must know that we are there to do everything we can for them, the right thing for them, short of asking us to participate in taking their life.

"There is a distinct difference between withholding treatment or stopping treatment . . . as opposed to actively taking the patient's life," Doctor Reardon said.

Doctor Quill said that sometimes even when everything is done for a patient, the patient still wants assistance in dving.

"Palliative care is the standard of care for people who are dying, but we also have an obligation to respond to those for whom good palliative care, applied without restraint, fails," Doctor Quill said.

"I think helping people die with dignity, with their integrity intact, is one of our highest callings," Doctor Quill said. "Patients want to be reassured that we will be there for them if they end up in their worst case scenario. But if they get good palliative care, very few will end up being there."

Doctor Gillon said his own opinion on physician assisted suicide has changed over time, from support to ambivalence, "maybe because I'm getting grayer," he quipped.

"There are problems on both sides," Doctor Gillon said. "I continue to sit uncomfortably on the moral fence, but doctors ought to obey the law as it stands now."

If the practice becomes accepted, he pointed out, low-income people or those with chronic, non-terminal, conditions may feel pressured into assisted suicide to avoid becoming a burden on their families or the state.

Public policy issues in genetic technology including privacy, insurance coverage and use of health care resources were discussed by the team of David J. Doukas, MD; Toby Citrin, JD;



Timothy E. Quill, MD(left); Thomas R. Reardon, MD (middle) and Raanan Gillon, MBBS, FRCP (right) address participants of the Bioethics Conference.

1998 Conference on Bioethics

October 2-4, 1998

Grand Hotel. Mackinge Island



MSMS Bioethics Committee Chair Howard A. Brody, MD, PhD (left), speaks with American Medical Association Board of Trustees Chair and Bioethics speaker Thomas R. Reardon, MD (right) during the Bioethics Conference.

on the Genome Policy Project.

"Much of the public feels there is something special about genetic testing that requires special laws," Professor Citrin said. "The longer we wait to create policy, the more fear will grow."

Just prior to the conference, Governor John Engler announced the establishment of the Michigan Commission on Genetic Testing,

and Leonard Fleck, PhD; who all are working which has been given the task of developing proposed laws in this emerging ethical area.

> The MSMS Mackinac Island Conference on Bioethics was supported by the Blue Cross Blue Shield of Michigan Foundation.

> The author is Director of Public Relations and Federation Planning for MSMS.



Timothy E. Quill, MD (right) addresses participants of the Bioethics Conference, while fellow panel members Thomas R. Reardon, MD(middle) and Raanan Gillon, MBBS, FRCP (left) await their turn to speak.

"I thought it was a terrific conference the diversity and seriousness of the participants was truly impressive. It was very provocative and on target for the issues we are facing in medicine today."

-Mary Anne Udow, Senior Vice President of Health Care Products and **Provider Services** for Blue Cross Blue Shield of Michigan

NEWSMAKERS

The AMA Board of Directors recently appointed MSMS Board Chair



K. Krishna Sawhney, MD, to the 12-member AMPAC Board of Directors for a onevear term.

Doctor Sawhney will join the AMPAC Board in meetings in Washington, DC, to determine which candidates the political action committee will support or attempt to defeat in coming elections. He is eligible to serve 10 terms. Doctor Sawhney currently chairs the Michigan Doctors Political Action Committee Board.

"I just love the political process," Doctor Sawhney said. "I find it to be very exciting. And I am thrilled to be part of AMPAC. I feel I can make an in-depth difference by being part of it."

Doctor Sawhney credits his interest in politics to colleagues such as Thomas E. Stone, MD, of Muskegon, Robert E. Paxton, MD, of Fremont and MSMS Managing Director Kevin A. Kelly.

Thomas C. Royer, MD, of Detroit, is the recipient of the Physician Ex-



ecutive Award for 1997. This award is given by the American College of Medical Practice Executives. Doctor Rover is senior vice president of medical affairs for Henry Ford Health System.

Mani Menon, MD, a Detroit urologist, was appointed chair of the Department of Urology at Henry Ford Hospital. Doctor Menon will oversee a department that will give thorough evaluations, consultations and a variety of other services to patients and staff.

Mark D. Hannis, MD, was appointed the new director of medical and continuing education for Oakwood Healthcare System. Doctor Hannis, having relocated from Greenville, NC, currently resides in Dearborn.

Nancy Mann, MD, was one of 32 women across the country selected



for the 1997-98 class of Executive Leadership Academic in Medicine. Doctor Mann, of Detroit, is chief of staff, assistant

vice president of medical affairs for The Detroit Medical Center's Rehabilitation Institute of Michigan and associate chair for the Department of Physical Medicine and Rehabilitation at Wayne State University School of Medicine.



Vivian M. Lewis, MD, a Flint pediatrician, is the fourth recipient of the Hurley Pinnacle Award. The Hurley award is presented biannually and is bestowed upon physicians who epitomize the height of professionalism, show unwavering commitment to the community, demonstrate dedication to the medical center and consistently and unfailingly embody Hurley's mission: Clinical Excellence. Service to People.

Oscar A. Carretero, MD, of Bloomfield Hills, recently was hon-



ored with the most prestigious international award for hypertension research—the 1997 Novartis Award for Hy-

pertension Research. Doctor Carretero is division head of hypertension and vascular research at Henry Ford Hospital.

OBITUARIES

Chauncey G. Burke, MD, died on August 4, 1997. He was 97. Doctor Burke, a Birmingham surgeon, graduated from the University of Chicago Medical School. He was a member of the American College of Surgeons, the American Medical Society of Vienna Austria, the Oakland County Medical Society, AMA and MSMS.

Ron J. Vander Belt, MD, died on September 21, 1997. He was 58. Doctor Vander Belt, an Ann Arbor cardiologist, graduated from the University of Michigan Medical School. He was a member of the Washtenaw County Medical Society and MSMS.

NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join other MSMS members at both local and state levels in achieving these goals.

Ephraim C. Ahanonu, MD, Detroit Abbas Syed Ali, MD, Alma Darrell E. Alley, Lansing John G. Anderson, MD, Grand Rapids Sarosh Anwar, MD, Saginaw Janet M. Bach, DO, Saginaw

Janet M. Bach, DO, Saginaw Thomas M. Basch, MD, Grand Rapids

Pradip K. Bhattacharyya, MD, Saginaw

Kulvinder S. Boparai, MD, Marshall Kenneth J. Bottesi, MD, Warren Craig V. Broussard, MD, Grand Rabids

Peter T. Bump, MD, Traverse City William L. Bush, MD, Grand Rapids Gregory L. Cammell, MD, Grand Rapids

Scott A. Carlson, MD, Grand Rapids Cynthia Casteel, MD, Jackson Kenneth R. Cervone, MD, St. Clair Shores

Natalie L. Chambers, MD, Grand Rapids

Richard T. Chambers, MD, Ada Keon Chang, MD, West Bloomfield Linda C. Chung-Honet, MD, Franklin

Susan M. Day, MD, Grand Rapids Daniel J. DeCook, MD, Holland Baljit S. Deol, MD, Grand Rapids Annette Faller, MD, Grand Rapids Robert J. France, MD, St. Clair Shores Chadwick A. Furness, MD, Grand Rapids

Kenneth J. Gaines, MD, Saginaw Robert S. Garcia, MD, Novi Joann N. Garvin, MD, Byron Center Ricardo Garza-Quintero, MD, Grand Rapids

Karen L. Gawel, MD, Grand Rapids Jeffrey E. Gorosh, DO, Rochester Hills Michael W. Grof, DO, Grand Rapids Michael J. Gruesen, DO, Wayne Kamal Gupta, MD, Brownstown Tahany M. Habashy, MD, Saginaw Stephen W. Halben, DO, Otter Lake Allen J. Hamaker, MD, Grand Rapids

Charles R. Harrison, MD, Grand Rapids

Michael J. Harrison, MD, Grand Rapids

Leanne Hatfield, MD, Marquette John C. Henry, MD, Livonia Staci E. Hill, Haslett Anand N. Hiremath, MD, Southgate Lisa Hoekstra, MD, Grand Rapids Robyn S. Hubbard, MD, Grand

Rapids

Robert C. Igwe, MD, Southfield Edward L. Johnson, MD, Flint Clara Kamath, MD, Roseville Sonya Khatiwala, MD, Walker Sunaina Khurana, MD, Carleton Sandra Kilian, MD, Jackson Steve Y. Kim, MD, Northville Stephen E. Kronberg, MD, Southfield Andrew J. Krutul, MD, Grand Rapids Edward J. Kryshak, MD, Grand Rapids

Jay P. LaBine, MD, Grand Rapids Patricia R. LaGrand, MD, Grand Rapids

Marianne K. Lange, MD, Grand Rapids

William F. Lange, MD, Marquette

Medley A. Larkin, DO, Saginaw Won Kyu Lee, MD, Grand Rapids Young J. Lee, MD, Warren Lisa M. Marshall, MD, Grand Rapids Minnie L. Martin, MD, Detroit Stephen McMahon, MD, Wyoming Sunil Menawat, MD, Saline Victoria L. Meredith, MD, Marquette John E. Miner, MD, Grand Rapids Hem P. Mohindra, MD, W. Bloomfield

Feroze A. Momin, MD, Dearborn Vittorio M. Morreale, MD, Detroit Daniel M. Navin, MD, Traverse City Eric A. Nelson, MD, Dearborn Christopher M. Nystuen, Ann Arbor Loretta R. O'Donnell, MD, Saginaw Michael E. Oates, MD, W. Bloomfield A. O. Odemuyiwa, MD, Farmington Christopher J. Oravitz, MD, Saginaw Augustine O. Osagie, MD, Southfield Damayanthi V. Pandrangi, MD, Flint John P. Papp, MD, Ada Kayur V. Patel, MD, Farmington Hills

Gregory A. Pinnell, MD, Saginaw Luis A. Pires, MD, Detroit Buenor D. Puplampu, MD, Grand

Rapids Jay Radhakrishnan, MD, Royal Oak Andrew Ramsahoi, MD, Ada Stanley G. Reedy, MD, Holland Robert E. Reneker, MD, Kentwood Saniya R. Sabzwari, St. Clair Shores Gary Salem, DO, Troy Martin Schuster, MD, Grand Rapids Douglas R. Shearer, MD, Marquette Sabet M. Siddiqui, MD, Grayling Craig Silverton, DO, Petoskey David R. Smith, MD, Okemos William J. Stanley, MD, Detroit David A. Steele, MD, Marquette Steven V. Stryk, MD, Novi Dennis R. Stuart, MD, Kalamazoo Burhan M. Tajour, MD, Flint

Colleen C. Tallen, MD, Grand Rapids

Judi L. Tassone, MD, Detroit Martin B. Trotsky, MD, W. Bloomfield Gordon A. Turner, MD, Grand Rapids

James A. Van Haren, MD, Grand Rapids

Gregory J. Van Wienen, MD, Jenison David M. Vandenberg, MD, Detroit Lyle J. Vander Schaaf, MD, Marquette

Donald J. Vandertoll, MD, Holland Neil D. Varner, DO, Saginaw Balasubramaniam Venugopal, MD, Grand Rapids

Patrick M. Webb, Okemos Lowell Weiner, MD, Flint Anne Hughes White, MD, Grosse

David A. Wiersema, DO, Saginaw Kim M. Winterhalter, MD, Holland David D. Wright, MD, Traverse City Randall T. Wurtz, MD, Farmington Hills

Muhammad Zulfiqar, MD, Farmington Hills



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DISCIPLINARY ACTIONS

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Commerce, Office of Health Services.

Name: George W. Williams, DO, 309 North St. PO Box 476, Gaylord, MI 49735

Action, Date Taken: Pharmacist & controlled substance licenses summarily suspended, license summarily suspended—8-26-97 Reason: Negligence/Incompetence, Lack of Good Moral Character—Drug Related Violations

Name: Andrejs Dimants, MD, PO Box 189, 1020 Millard St., Three Rivers, MI 49093

Action, Date Taken: License suspended—6 months & 1 day, fine \$1,000.00—9-01-97 Reason: Drug related

Name: M. A. MacDonald, MD, 1324 W. Milham, Portage, MI 49024

Action, Date Taken: License revoked, fine \$1,000.00— 9-19-97 Reason: Violation of General Duty/Negligence

Name: Almon L. Schut, MD, 252 East Lovell, Ste. 255, Kalamazoo, MI 49007

Action, Date Taken: Reprimand, fine \$1,000.00, probation—2 yrs.—9-5-97 Reason: Failure to Meet Continuing Education Requirements.

Name: Garland D. Scott, Jr., MD, 1100 E. Michigan, Ste. 204, Jackson, MI 49201

Action, Date Taken: Reprimand, fine \$1,000.00, probation—2 yrs.—9-12-97 Reason: Failure to Meet Continuing Education Requirements.

Name: Lee N. Stroia, MD, 200 S. Wenona, Bay City, MI 48706

Action, Date Taken: Reprimand, fine \$1,000.00, probation—2 yrs.—9-5-97 Reason: Failure to Meet Continuing Education Requirements.

Name: Claude R. Young, DO, 8500 Fourteenth St., Detroit, MI 48206

Action, Date Taken: Cease and desist—7-19-97 Reason: Employment of a health professional with an educational limited license

Name: Walter J. Gawel III, DO, 4615 Eastman Ave., Midland, MI 48640

Action, Date Taken: License summarily suspended— 9-22-97 **Reason:** Mental/Physical inability to practice

Name: James R. Chenoweth, MD, 5676 Wagoneer Ct., Ann Arbor, MI 48103

Action, Date Taken: Reprimand, fine—\$1,000.00, probation—2 years—9-12-97 Reason: Failure to meet continuing education requirements

Name: Richard F. Schultz, MD, 243 W. Borad St., Chesaning, MI 48616

Action, Date Taken: Reprimand, fine—\$1,000.00, probation—2 years—9-15-97 Reason: Failure to meet continuing education requirements

Name: Napoleon C. Imperio, MD, 15800 W. McNichols, Detroit, MI 48235

Action, Date Taken: Reprimand, fine-\$1,000.00, probation—2 years—9-12-97 Reason: Failure to meet continuing education requirements

Name: Carol L. Scot, MD, 1100 W. Saginaw, Ste 401, Lansing, MI 48915

Action, Date Taken: Probation-2 years fine-\$1,000.00—10-17-97 Reason: Negligence/IncompeMichigan Medicine carries a list each month of opportunities in Michigan for doctors to obtain Category I credits toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar. Each listing below, of programs that carry at least four hours of Category I credit, indicates a contact person so the physician can obtain information. Physicians with questions about accredited programs may phone MSMS headquarters at (517) 337-1351.

DECEMBER

5-7, Dermatology for the Non-Dermatologist. Location: Marriott Marquis, New York, NY. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

9, 16, Bar-Levav Educational Association Ongoing Seminar Series "Specifically, How to Repair Defective Boundaries of the Self. " Location: 3000 Town Center, Suite 1275, Southfield, MI Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI, 48075, (248) 353-3333. Approved for: 4 Category 1 credits.

11-13, Coronary Heart Disease Update. Location: Atlantis Paradise Resort, Nassau, Bahamas. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

12-14, Arrhythmias: Interpretation, Diagnosis & Management. Location: Monte Carlo Hotel, Las Vegas, NV. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

12-14, Neurology for the Non-Neurologist. Location: Camelback Inn, Scottsdale, AZ. Contact: Linda Main, Meetings Coordinator, Medical Education Resources, 1500 West Canal Court, Suite 500, Littleton, CO, 80120-4569, (800) 421-3756. Approved for: 11 Category 1 credits. Registration Fee: \$375.00.

23, 30, Bar-Levav Educational Association Ongoing Seminar Series "The Basis for Clinical Authority in Medicine. "Location: 3000 Town Center, Suite 1275, Southfield, MI Contact: Lester Potempa, DO, Bar-Levav Educational Association, 3000 Town Center, Suite 1275, Southfield, MI, 48075, (248) 353-3333. Approved for: 4 Category 1 credits.

JANUARY

12-16, Bone and Soft Tissue Tumors: A Multidisciplinary Approach. Location: Ihilani Resort, Oahu, Hawaii. Contact: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First St. S.W., Rochester, MN 55905; (800) 323-2688; or fax (507) 284-0532. Approved for: 30 Category 1 credits. Registration Fee: \$750.00.

Distance-learning CME opportunity

Michigan State University is pleased to announce Issues in Health Care Ethics, a new distance-learning course designed for institutional ethics committee members. This is a pilot course that will test the feasibility of a distance-learning based health care ethics certificate program.

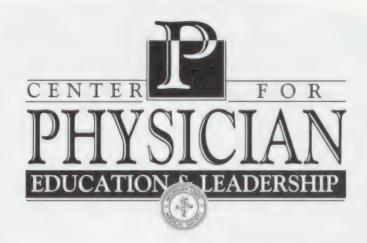
Issues in Health Care Ethics is a survey course of the major issues pertinent to the work of, institutional ethics committees. The goal of the course is to insure that every participant is familiar with the vocabulary, basic reasoning and key texts regarding central issues in health care ethics.

Issues in Health Care Ethics will be run entirely on the World Wide Web. This provides the following advantages:

- The only physical requirement is that they have convenient access to a computer equipped with a web browser like Netscape or Internet Explorer.
- The course will follow a schedule organized around weekly topics and assignments, but participants may do their work in the morning, afternoon or evening—whatever fits their home and work schedule.

The course will be offered in the Spring 1998 Semester (January 14 through May 8). In order to ensure more personalized attention enrollment is limited to 20 participants.

A course preview is available online at http://iphh.cal.msu.edu/ web ethics/preview/syllfrm2.htm. Approved for: 45 Category 1 credits. Registration fee: \$648.00



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New E&M documentation coding guidelines will be effective January 1, 1998. "Coding for Physicians," is a three-hour workshop to prepare physicians and office staff for upcoming changes in order to avoid costly audits

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Understanding Capitation

Learn survival strategies that will benefit your practice in a capitated system. Keep control in the changing health care economy, and be more proactive and profitable by understanding capitation, risk sharing models and contract negotiation.

Managed Care Contracting

Learn the ins and outs of negotiating managed care contracts. This seminar provides in depth information on what to look for and what to avoid when negotiating a contract with a managed care organization.

Valuing Your Practice for Mergers, Acquisitions or Sales

Medical integration is becoming one of the strongest themes for physicians in this decade. This seminar will give physicians information concerning the merger and consolidation of practices, including a review of legal, financial and operational issues that should be discussed when consolidating medical practices.

For information or to schedule a seminar, please contact Mary Jensen, education coordinator at (517) 336-5706 or e-mail mjensen2@msms.org.

MSMS has created an educational development center to assist physicians and their staff in providing care to their patients more effectively and efficiently, while continuing to provide physicians with high quality, clinical education. The center is now developing programs for physicians regarding managed care, practice management, telemedicine and the legal aspects of medicine.

MSMS also is developing a medical business specialist program. The program will include coding workshops and insurance billing seminars along with pro-

grams to help office staff and medical group managers provide higher quality services to patients, and to improve the efficiency of the physician's practice.

Look for physician and office staff programs beginning in 1998. Watch future issues of Michigan Medicine and Medigram for details as these important new programs develop. For information contact Deborah Zannoth, chief of professional development at (517) 336-5767; or via e-mail at dzannoth@msms.org; or contact Mary Jensen, education coordinator at (517) 336-5706, or via e-mail at mjensen2@msms.org.



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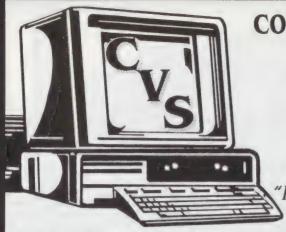
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of Michigan. Recreational activities abound in Escanaba, including golf, sailing and skiing in a beautiful and safe environment. This position is hospital employed and includes a comprehensive benefits package. For more information, contact: Wendy Bass at (800) 462-3621, or fax your CV to (309) 685-2574.

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accept many

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other terms of

"Unions" continued from page 33

from judicial intervention if they arise from a labor dispute and the defendant is a party to the dispute. When read together with the Clayton Act, it is clear that these nine activities are exempt from the antitrust laws.

The second is the National Labor Relations Act (also known as the Wagner Act) passed in 1935. It created the National Labor Relations Board, and is the basis for today's comprehensive federal code that regulates labor relations. This Act does not contain an express exemption from the antitrust laws. Instead, it is a reference point for defining the activities that are exempt. The Act creates a legally enforceable right for employees to organize, requires employers to bargain with employees through employee-elected representatives and gives employees the right to engage in concerted activities for collective bargaining purposes or other mutual aid or protection.

The third is the Labor Management Relation Act (also known as the Taft-Hartley Act) passed in 1947. It builds upon and corrects problems and inequities that had developed in the enforcement of the National Labor Relations Act. The fourth is the Labor Management Reporting and Disclosure Act (also known as the Landrum-Griffin Act) passed in 1959. It also corrects problems and inequities that developed in the enforcement of the National Labor Relations Act and the Labor Management Relations Act. Neither of these acts has an express antitrust exemption, but they are used to define the scope of the exemption in the Clayton Act.

Finally, federal courts have decided cases that interpret the scope of the exemption when the four labor relation statutes do not provide enough guidance, or when they do not apply to the workers who want to engage in collective bargaining. The rules of law developed in these cases are referred to as the "non-statutory" exemption.

To fall within the labor exemption, the activities involved must meet the following characteristics:

- The conduct must arise out of a "labor dispute" and must be the conduct of a "labor organization."
- The labor organization must be acting in its own self interest—it should be acting to further its goals as a labor organization as opposed to the goals of another entity.
- The activities must involve the unilateral conduct of the labor organization. Collective action carried on with other entities, especially if those entities are not labor organization, may violate the antitrust laws.

Ability of physicians to engage in collective bargaining

Employed Physicians. Physicians who are employees fall within the labor exemption to the antitrust laws, and may engage in collective bargaining with their employers. However, physician employees who have attempted to form unions have not always had an easy path. Some courts have found that physicians are supervisory employees because their decisions direct other members of the health care team such as nurses and technicians. When physicians are found to be supervisory employees as opposed to non-supervisory

Self-Employed Physicians. Before physicians can engage in collective bargaining under the labor exemption, the bargaining process must be part of a labor dispute. For there to be a labor dispute, the collective bargaining must concern the terms and conditions of employment. Therefore, the physicians must be employees. There is no dispute for purposes of the labor exemption if the physicians are independent contractors, entrepreneurs or independent businesses.

Self-employed physicians are not in an employment relationship. Instead they are in independent practice. They are generally considered to be independent contractors, entrepreneurs or independent businesses who do not qualify for the labor exemption.

However, in recent year, physicians in independent practice have lost authority to health plans and hospitals. In addition, health plans have enough economic leverage that physicians often feel compelled to accept many other terms of dealing.

Some have argued that physicians who are not employees of a hospital or a health plan, but who are subject to a high degree of control by the hospital or health plan, should qualify for the labor exemption because they are not truly independent. This is a legitimate issue: the fact that persons who seek to engage in collective bargaining are not in a formal employment relationship does not conclusively disqualify them from the labor exemption. Courts will look at the nature of the relationship to determine whether the persons are employees in substance even though they do not have a formal employment relationship. Employers cannot escape the labor exemption and the protection extended to employees by the National Labor Relations Act and its successor statutes by calling their workers independent contractors instead of employees.

For the full text of this AMA report, please see the Michigan Medicine on the MSMS Internet homepage at http://www.msms.org/



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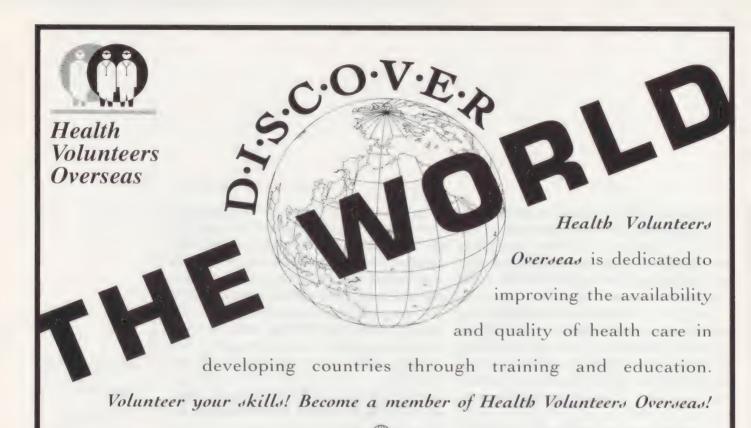
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Medical Staffs in Hospital Mergers

By Peter A. Duhamel, MD



Mergers of hospitals have been occurring at a steadily increasing rate. In 1995, the last year for which we have statistics, 735 of the nation's hospitals were involved in mergers and acquisitions, topping by nine percent the large volume of transactions in 1994. Those hospitals were involved in 230 mergers or acquisitions, as compared to 184 deals in 1994.

The states with the greatest number of mergers and acquisitions were Florida, Texas and California, with a surprisingly large number in Wisconsin. In Michigan there were eight mergers in 1994, and five in 1995.

We who have been active in the AMA's Organized Medical Staff Section (formerly Hospital Medical Staff Section), have long held serious concerns regarding the impact of these mergers, acquisitions, affiliations and consolidations on the involved hospital medical staffs.

Staffs had no knowledge

The evidence would indicate that the vast majority of these deals are financially driven, related to managed care, business pressures, and a significant reduction in inpatient utilization. In most of these arrangements, the negotiations between the parties were carried out in secrecy, with the medical staffs having no knowledge of the proposed union until the deal had been struck.

The AMA Organized Medical Staff Section approved a Report of its Governing Council last December (Report B, I-96, Hospital Affiliation and Mergers). This Report summarized several aspects of hos-

pital mergers and their impact on the medical staffs. It is based in part on in-depth telephone interviews with current chiefs of staff in 30 hospitals across the United States that merged between 1993 and 1995, and also on a study published in the Fall 1995 issue of Hospital and Health Services Administration, whose principal author was Gary D. Maynard, MD, Dallas, former chair, MSMS Hospital Medical Staff Section, and past speaker, MSMS House of Delegates.

The report recomemds:

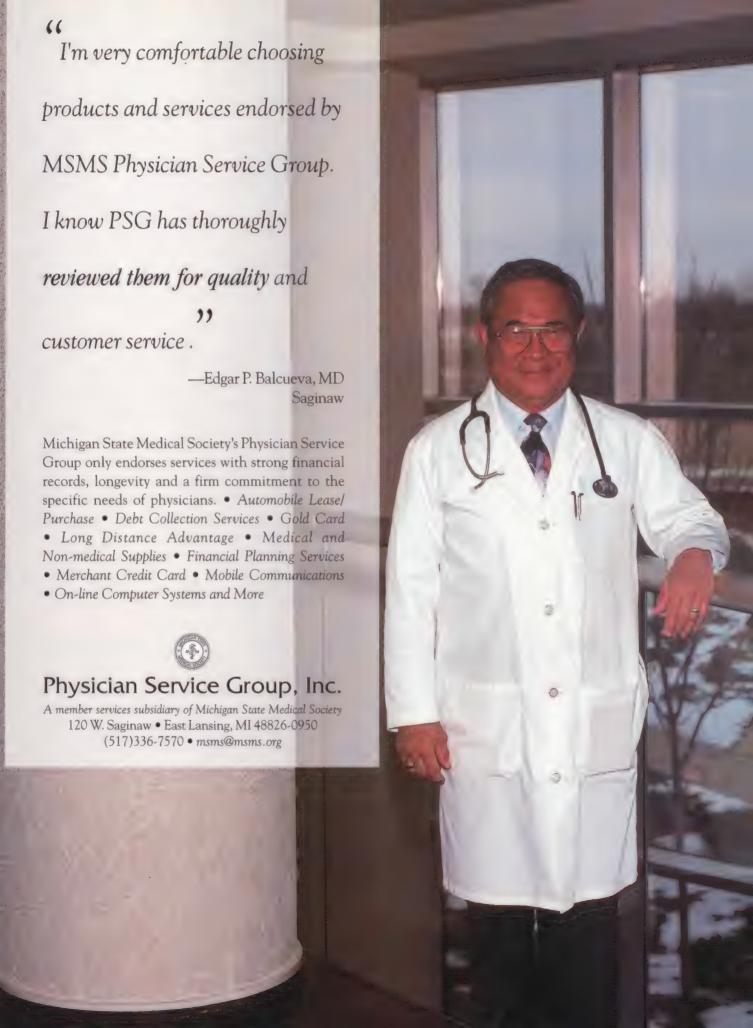
- The hospital governing body and management must involve the medical staff early in merger plans and in every aspect of the merger. acquisition, conversion or affiliation.
- An officially recognized joint committee of the governing body and the organized medical staff should be in place or created to resolve all issues of concern, including but not limited to the hospital merger, for both the governing body and the medical staff.
- It should be recognized that change and uncertainty can precipitate an environment of anxiety; consequently, there must be a mechanism to share information regarding the merger or consolidation with the medical staff executive committee and the members of the medical staff.
- The leaders of the medical staff must be able to bring to the decision-making table the issues of existing and resultant relationships of the organized medical staffs such as overlap of physicians on the medical staffs, variations and resolution of those variations in credentialing and privileging.

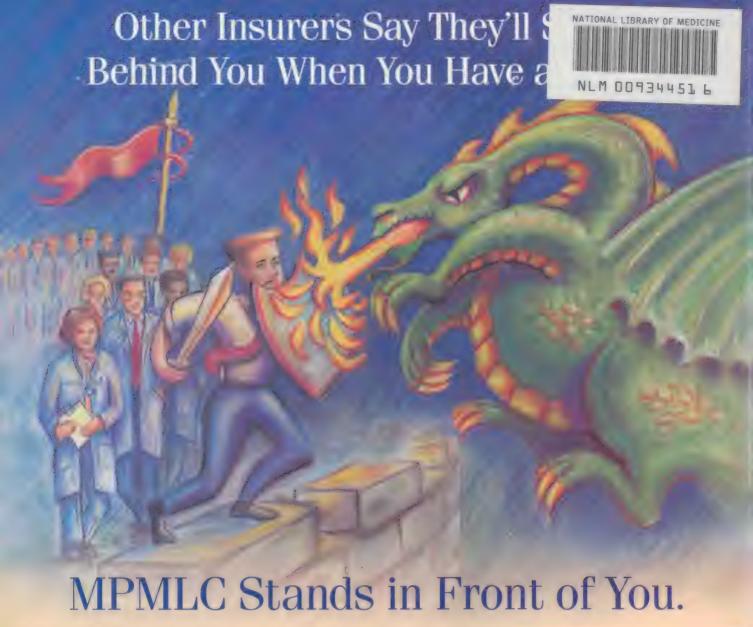
- The medical staffs from the merging/consolidating hospitals should form a joint committee to address and resolve any differences regarding organizational structure. medical staff bylaws, credentialing processes, continuous quality improvement/utilization review, peer review and other medical staff func-
- The medical staffs of each should take the initiative and have the responsibility and authority to resolve physician disputes that arise from the merging of the physicians at different institutions. Examples of these issues may include:

Merging of physician departments, especially hospital-based physician departments, such as radiology, pathology, anesthesiology or emergency medicine. Tailoring stipulations for determination of competence in physician privileging. Quality assurance and utilization review. Peer review and due process. Privileging. credentialing and recredentialing.

Effect on physicians

Michigan Medicine's cover story this month is devoted to the subject of hospital mergers. It is the first in a series of articles that will explore the many ramifications of mergers and acquisitions on Michigan physicians' medical practices—and their lives in general. We invite our members' comments on mergers and acquisitions in their own lives, and what MSMS can do to help. For further information or assistance call F. B. "Tom" Plasman (517) 336-5724; or e-mail him at tplasman@msms.org.





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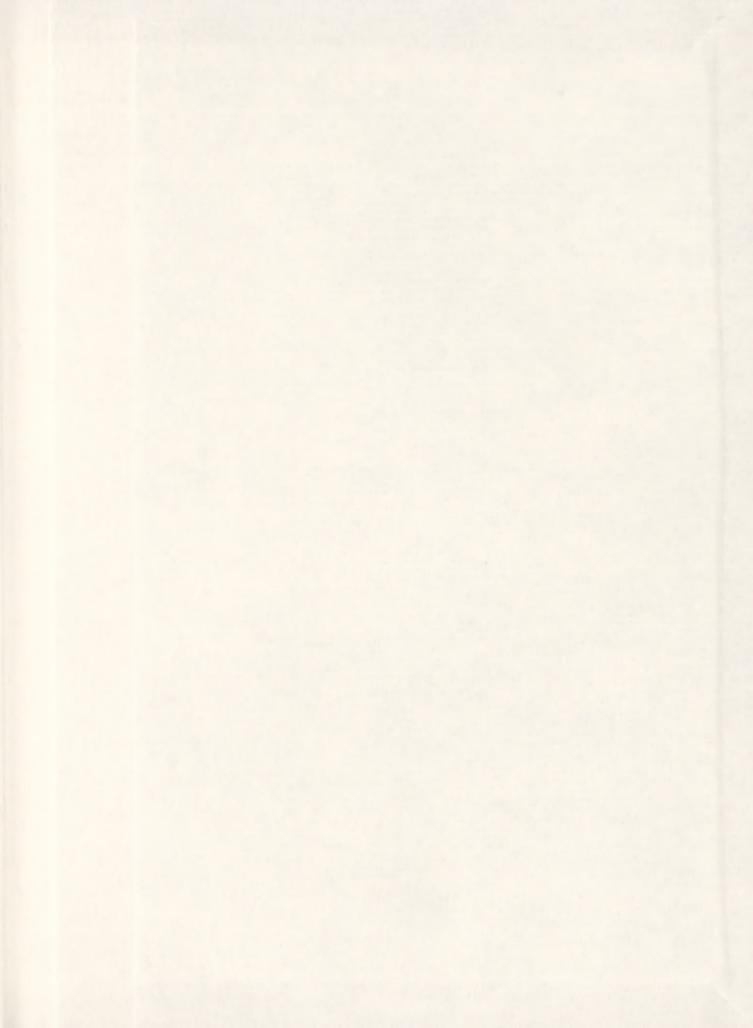
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